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HEALTH CARE FRAUD: MILKING MEDICARE AND MEDICAID

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

ONE HUNDRED FOURTH CONGRESS

FIRST SESSION

WASHINGTON, DC

NOVEMBER 2, 1995

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CONTENTS

HEALTH CARE FRAUD: MILKING MEDICARE AND MEDICAID

THURSDAY, NOVEMBER 2, 1995

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The committee met, pursuant to notice, at 10:08 a.m. in room 562, Senate Dirksen Building, Hon. William S. Cohen (chairman of the committee) presiding.

Present: Senators Cohen, Burns, Pryor, Reid, Kohl, and Feingold.

Staff present: Mary Berry Gerwin, staff director; Priscilla H. Hanley, professional staff; Helen M. Albert, investigator; Theresa M. Forster, Minority staff director; Ken Cohen, investigator; Sally J. Ehrenfried, chief clerk; Elizabeth Watson, system administrator; Lindsey Ledwin, staff assistant.

OPENING STATEMENT OF SENATOR WILLIAM S. COHEN, CHAIRMAN

The CHAIRMAN. The committee will come to order.

This morning the Senate Special Committee On Aging is continuing its series of hearings on health care fraud and abuse. Over the past 3 years, the committee has been investigating the explosion of fraud throughout the health care system, and, in particular, fraud against Medicare and Medicaid. Last spring the Medicare Trustees, on a bipartisan basis, issued its urgent warning that the Medicare Hospital Trust Fund is going to go bankrupt by the year 2002 unless major changes are made to protect the system.

Since that alarm was sounded, Congress has been wrestling with ways to bring Medicare spending under control. Similarly, major changes are going to be made in Medicaid spending. The budget proposal is now being considered in conference. It would turn Medicaid over to the States in the form of block grants in order to give the States more flexibility in how they spend these dollars.

The budget deliberations are on precisely how to curb Medicare and Medicaid spending and has now moved to conference. I expect, it will continue for weeks and perhaps even longer.

A major step we can and must take toward Medicare and Medicaid reform is to crack down on fraud and abuse that drives up the cost of health care for senior citizens and taxpayers. Estimates are that Medicare and Medicaid combined lose about $33 billion each year to fraud and abuse, and that losses in the entire health care system itself and to our economy to fraud exceed $100 billion every year.

This committee's investigation has revealed that it is appallingly easy to commit health care fraud because the size, complexity, and splintering of the current health care system creates an environment that is ripe for abuse. Health care fraud is an equal opportunity employer that does not discriminate against any part of the system. All government health care programs—Medicare, Medicaid, CHAMPUS, and other Federal and State health care plans, as well as those in the private sector—are being ravaged by fraud and abuse. Similarly, no one type of health care provider or provider group corners the market on health care fraud. Scams against the system run the gamut from small companies or practitioners who occasionally pad their Medicare billings because they know they will never get caught to very large criminal organizations that steal millions of dollars from Medicare, Medicaid and other insurers.

Earlier this year, this committee heard testimony from FBI director Louis Freeh that health care fraud is growing much faster than law enforcement ever anticipated, and that even cocaine distributors are switching from drug dealing to health care fraud schemes because the chances of getting caught are so small and the profits are so large.

Of particular concern to this committee is the growing evidence that health care fraud is systematic in the health care industries providing services to our Nation's elderly and disabled Americans. The Inspector General of the Department of Health and Human Services, for example, has cited problems in home health care, nursing home, and medical supplier industries as significant trends in Medicare and Medicaid fraud and abuse. Padding claims and cost reports, charging the government and patients outrageous prices for services, and billing Medicare for costs that have nothing to do with patient care are just a few of the schemes occurring in these industries. Unscrupulous providers are now enjoying a feeding frenzy on Medicare and Medicaid while the taxpayers are paying the tab for their feast.

Today's hearing will provide a brief glimpse of how easy and lucrative it is to rip off Medicare and other health care systems or programs. This morning we're going to hear from three individuals who will describe how easy it is to defraud the Medicare and Medicaid programs of millions of dollars.

Medicare has provided a lavish lifestyle for some who unscrupulously bilk the system at the expense of taxpayers and senior citizens. For example, today we're going to hear about the house that Medicare built—this beautiful $2.5 million custom-built mansion was paid for with money from phony Medicare billings.

We're also going to hear about how a Medicare billing service was paid over $7 million for filing false claims on surgical dressings supplied to nursing homes. Further, we will hear testimony from a doctor who was involved in the so-called "South Grand Scam", a clinic scam in Los Angeles, involving phony prescriptions and paid patients, which resulted in Medicaid losses of over $800,000. Today, we've also asked the General Accounting Office, and the Attorney General of New York, Dennis Vacco, to describe the major areas of health care fraud they have identified, and what we must do to make it easier for Medicare and Medicaid

and law enforcement to prevent, identify, and to prosecute health care fraud. The testimony of these witnesses, as well as many examples that we have uncovered through our 3-year investigation clearly prove it's time that we crack down on and shut down these schemes that are bilking billions of dollars from Medicare and other health care programs.

If we're asking honest health care providers to take cuts in reimbursement, asking Medicare and Medicaid recipients to pay more out of pocket costs to bring spending under control, we have an absolute duty to ensure the American public that their health care dollars are not lining the pockets of criminals and greedy providers who are manipulating the system through fraud and abuse.

I'm pleased that the budget reconciliation bill recently approved by the Senate includes anti-fraud legislation that I introduced earlier this year as a result of this committee's investigation. This proposal creates tough new health care fraud statutes, it increases fines and penalties for billing Medicare and Medicaid for unnecessary services, overbilling, and for other frauds against these and all Federal health care programs, and makes it easier to kick fraudulent providers out of the Medicare and Medicaid programs, so they don't continue to rip off the system.

The Senate bill establishes an anti-fraud and abuse program to coordinate Federal and State efforts against health care fraud, and substantially increases funding for investigative efforts, auditors, and prosecutors by throwing back a portion of fines and penalties collected from health care fraud efforts to law enforcement itself.

According to the Congressional Budget Office, CBO, these provisions in the Senate bill yield over $4 billion in scorable savings without costing a penny to senior citizens. At the same time the Senate bill is tough on fraud, it also provides important guidance to health care providers on what anti-fraud rules are, so that honest providers don't get tripped up by the law. While the House Budget Bill also contains some important fraud measures, I am concerned that the House proposal contains some provisions that would dilute current, anti-health care fraud statutes, and I hope that the conferees in this legislation will adopt the tougher Senate provisions.

Finally, I have asked GAO to testify this morning on ways that we can protect Medicaid and Medicare defenses against fraud and abuse. The lax practices of Medicare I think are outrageous, they are costly, and they cry out for reform.

So we're looking forward to hearing the testimony today, and I thank my colleague, Senator Feingold, who has just arrived and whom I will yield to in a moment, but I want to thank all of my colleagues on the Aging Committee for their strong support for health care fraud legislation, and in particular, Senator Pryor, the ranking member.

[The prepared statement of Senator Cohen follows:]

STATEMENT OF SENATOR WILLIAM S. COHEN

This morning the Senate Special Committee on Aging is continuing its series of hearings on health care fraud and abuse. Over the past 3 years, the committee has been investigating the explosion of fraud throughout the health care system, and, in particular, fraud against the Medicare and Medicaid programs.

Last spring the Medicare Trustees, on a bipartisan basis, issued its urgent warning that the Medicare Hospital Trust Fund will go broke by the year 2002, unless major changes are made to protect the system. Since that alarm was sounded, the Congress has been wrestling with ways to bring Medicare spending under control.

Similarly, major changes will be made in Medicaid spending, under whose weight many State budgets are bursting. The budget proposals now being considered in conference would turn Medicaid over to the States in the form of block grants, in order to give States more flexibility in how they spend these dollars.

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Health care fraud is an equal opportunity employer that does not discriminate against any part of the system. All government health care programs—Medicare, Medicaid, CHAMPUS, and other Federal and State health plans, as well as private sector health plans, are ravaged by fraud and abuse.

Similarly, no one type of health care provider or provider group corners the market on health care fraud. Scams against the system run the gamut from small companies or practitioners who occasionally pad their Medicare billings because they know they'll never get caught to large criminal organizations that steal millions of dollars from Medicare, Medicaid, and other insurers. Earlier this year, this committee heard testimony from FBI Director Louis Freeh that health care fraud is growing much faster than law enforcement ever anticipated, and that even cocaine distributors are switching from drug dealing to health care fraud schemes because the chances of being caught are so small—and the profits are so big.

Of particular concern to this committee is the growing evidence that health care fraud is systematic in the health care industries providing services to our Nation's elderly and disabled Americans.

The Inspector General of the Department of Health and Human Services, for example, has cited problems in home health care, nursing home, and medical supplier industries as significant trends in Medicare and Medicaid fraud and abuse. Padding claims and cost reports, charging the government and patients outrageous prices for unbundled services, and billing Medicare for costs that have nothing to do with patient care are just a few of the schemes occurring in these industries.

Unscrupulous providers are enjoying a feeding frenzy on Medicare and Medicaid, while taxpayers are paying the tab for their feast.

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Further, we will also hear testimony from a doctor who was involved in the so-called "South Grand Scam", a clinic scam in Los Angeles involving phony prescriptions and paid patients, which resulted in Medicaid losses of over $800,000.

Today we have also asked the General Accounting Office and the Attorney General of New York, Dennis Vacco, to describe the major areas of health care fraud they have identified and what we must do to make it easier for Medicare and Medicaid and law enforcement to prevent, identify, and prosecute health care fraud.

The testimony of these witnesses, as well as the many examples we have uncovered through our 3 year investigation clearly prove that it is time that we crack down on—and shut down—these schemes that are bilking billions of dollars from Medicare and other health care programs.

If we are asking honest health care providers to take cuts in reimbursement and asking Medicare and Medicaid recipients to pay more out-of-pocket costs to bring spending under control, we have an absolute duty to ensure the American public that their health care dollars are not lining the pockets of criminals and greedy providers who are manipulating the system through fraud and abuse.

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Finally, I have asked the GAO to testify this morning on ways that we can shore up Medicare and Medicaid defenses against fraud and abuse. The lax practices of Medicare are outrageous and costly, and cry out for reform.

I look forward to hearing the testimony today and thank my colleagues on the Aging Committee for their strong support of strong health care fraud legislation.

Senator Feingold.

OPENING STATEMENT OF SENATOR RUSS FEINGOLD

Senator FEINGOLD. Thank you, Mr. Chairman. I will just speak very briefly so we can get on with the hearing, but I want to thank you and the ranking member and especially the staff of the Aging Committee for the work that went into this hearing. Today's hearing follows up on the work done last year by the Aging Committee staff, and I think it again demonstrates the need for this committee as an important focal point for issues concerning older people.

The Chairman has been a leader in this area and the provisions and the reconciliation measure passed by the Senate were largely the result of his work and the work of this committee, although in the end, neither the Chairman nor I supported the final product as a whole.

I look forward to hearing what today's witnesses have to say on the subject of waste, and fraud and abuse in our health care programs. The cost in lost resources is remarkable, resources that are all the more dear because of our Federal budget programs. As we explore this area, let me just relate for 1 minute some observations from Wisconsin.

As a member of the Wisconsin State Senate for 10 years, we saw provisions intended to restrict inappropriate utilization do little to improve care for consumers. Instead, they too often actually created real barriers to needed health care services. These restrictions tended to be what I would call "bureaucrat-friendly," emphasizing approaches, such as prior authorization requirements, that were centered around a distant bureaucracy, reviewing paperwork instead of conducting field audits or onsite consumer interviews and other consumer centered reviews that enhance both compliance with the law and quality assurance for consumers.

So, with that note of caution, I again thank the Chair and look forward to hearing from the witnesses.

The CHAIRMAN. Thank you very much, Senator Feingold.

I am going to ask the cameras to turn away from the witnesses. Just point your cameras straight against this wall. The first two witnesses will be unidentified, and I'm going to call them in a moment.

Our first panel will give their first-hand experiences in health care fraud.

We have Mr. A. who will testify how easy it was to open a home health care company and then fraudulently bill the Medicare system.

Doctor B. is going to testify of his involvement in a clinic, which operated a Medicaid billing scam, and he is accompanied by Hardy Gold of the California Department of Justice, Bureau of Medi-Cal fraud, and he will also answer questions on how this scheme operated.

Finally, Kristina Brambila will testify how she set up a billing service that fraudulently billed the Medicare program for surgical dressings provided to nursing homes.

Again, I hope that all cameras will be turned away from these witnesses. Two of the three witnesses have asked to be shielded, and the cameras can resume as soon as the witnesses are fully seated behind the screen. I would also ask that at the conclusion of their testimony that we follow the same procedure.

So if we could just bring the witnesses in.

Mr. A, do you have a statement that you would like to deliver?

Mr. A. Yes.

STATEMENT OF "MR. A.," HEALTH CARE FRAUD VIOLATOR

Mr. A. I am testifying before you today because I participated in a criminal scheme that caused the loss of millions of Medicare program dollars.

On September 25, 1995, I plead guilty to a five-count information, charging me with mail fraud and conspiracy, for my role in a scheme I started about April 1992 that defrauded the Medicare program of between $1.5 and $2.5 million, until it ended by November 1993. I want you to know how easy it was for me to open a home health care agency that Medicare paid $5.6 million in 17 months. This was especially remarkable because 13 months before I set up the agency, I was in prison serving a sentence for sale of controlled substances and my business experience was obtained as an owner of a nightclub.

After I got out of prison in March 1991 I got some money from an auto insurance lawsuit and was looking for a legitimate business to get into. I met a nurse in a nightclub who suggested I should open a home health care agency with her, which I did in the early part of 1992, making her part owner and calling it United Care Home Health Services, Inc. We applied to the County of Los Angeles, Department of Health Services, Licensing Division, for a home health care license and Medicare certification, put together a policy manual, signed a lease, purchased a computer and began to look for ways to get some patients. I brought my friend, who was a former nightclub manager who was in prison with me, into the business.

We decided to market our services to doctors and went to one doctor in South Central, Los Angeles. After describing our new agency and services to him, we asked him to do business with us by referring his patients. The doctor refused to do business with us unless he was compensated. He told us he had thousands of patients, and he wanted $100 per patient referred to start. My nurse partner did not want me to pay a kickback to the doctor and was very upset but I agreed to do so. In fact, she left the business shortly after.

The Department of Health Services told me my experience as a nightclub owner would qualify me to be administrator of a Medicare certified agency, and they processed my application, but I still needed my first three patients in order to become certified.

I had sunk almost all of my insurance money into this business and did not have much money left. Desperate for patients, I went back to the doctor. He gave me the names, insurance numbers, and diagnosis codes for three of his patients, and I gave him $300 in cash. We also marketed our services to a few other doctors and started to get some patients from them, but I got most of my patients by paying one doctor for them.

On April 10, 1992, my agency was certified. It was a short time later that I got my Medicare provider number and was allowed to bill Medicare by submitting hard copy insurance claims. At first, the claims to Medicare were for patients who were actually sick and needed home health care, and we were providing the services. Medicare paid us $86 for each home health care visit to be made, and we only had to pay the home health aides $16 and the nurses $22 for each visit.

About December 1992 Medicare suggested we have a computer direct data entry system installed that would allow us to send our claims into Medicare electronically with no hard paper.

This is when we really got into trouble and when we began sending in bogus Medicare claims. The direct data entry system made it easy for us to submit Medicare claims for patients to whom we never provided any services. All we needed was a name, a health insurance number, and a code for the diagnosis. In fact, by January 1993 we were billing Medicare for patients who either did not live at the address we submitted to Medicare, had not been seen by a doctor in over 5 years, were not home bound, were in a hospital, or were deceased. Medicare did not require any paperwork at the time we sent the claim in electronically.

We also paid a nurse $10,000 to be able to bill Medicare for the home health visits she was making to patients who lived in a large retirement home. We later found out that the notes for the visits the nurse said were performed were all photocopies of the same note with different dates of services. This nurse was trying to sell her patients to other agencies as well.

Medicare only wanted to see signed physician certifications and plans of treatment if they decided to review a claim, and we were in business and had been paid millions of dollars for fraudulent home health claims before Medicare even began to ask for any documentation that the services were ordered by a physician or were actually performed. When Medicare/Blue Cross finally asked us for

bogus patient's medical records, we had to pay our nurses to write up notes and create fraudulent medical records to send in.

The quality of these phony records was not very good, so Medicare began to deny some of the claims, but they paid us some claims anyway. This is called waiver of liability. After they denied the visits, but paid us anyway, Medicare sent notices to the patients about the bills we had sent in their names. Some of these patients were surprised to learn we had billed Medicare for home health services since we had not provided any. A few patients called us and complained. Unless there is a medical review of Medicare claim, Medicare does not tell the patient what has been billed for them by a home health agency. Home health agency patients do not receive Explanation of Medicare Benefits like patients of doctors.

We did talk to some nice ladies at Blue Cross who questioned us about why we were billing Medicare for home health services given to dead people, but we just told them we made a mistake and we were not paid for most of these claims.

It is very easy and very tempting to sit on a computer and submit claims electronically to Medicare for services that were not provided. We did not start out to do this, but it was just too easy. Blue Cross data shows we submitted over 9,000 claims for over 80,000 home health visits to 680 different patients during our 17 months of operation. We were paid $5.6 million and between $1.5 and $2.5 million of that was for the fraudulent claims we sent in electronically during the last 8 months of our operation. We were making so much money that I was able to have a custom home built in Bel Air for $2.5 million, of which I put down $1.2 million. I also leased a Rolls Royce and leased a 500 SL Mercedes Benz. I also invested hundreds of thousands of dollars in a movie production company and movie script about my life. I have also published a book about my life that includes a chapter about United Care Home Health Services, which I will have to revise to include my guilty plea and what awaits me now.

This concludes my prepared statement, and I would like to try to answer any questions you may have of me.

[The prepared statement of Mr. A. follows:]

PREPARED STATEMENT OF MISTER A

I am testifying before you today because I participated in a criminal scheme that caused the loss of millions of Medicare program dollars.

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about my life. I have also published a book about my life that includes a chapter about United Care Home Health Services which I will have to revise to include my guilty plea and what awaits me now.

This concludes my prepared statement and I will try to answer any questions you may have of me.

The CHAIRMAN. I regret to say that the offers you receive for your book will probably go up now as a result of your conviction and guilty plea, given the system that we see prevailing in our society. We will come back to you, Mr. A.

Mr. B.

STATEMENT OF "DOCTOR B.," HEALTH CARE FRAUD VIOLATOR; ACCOMPANIED BY HARDY GOLD, CALIFORNIA DEPARTMENT OF JUSTICE, BUREAU OF MEDI-CAL FRAUD

Doctor B. I'm a medical doctor who graduated from a prestigious medical school, Emory University in Atlanta, Georgia, but I lost my privilege to practice medicine because I have stolen from Medicaid and wrote illegal prescriptions to junkies. I have been a healer who saved people's lives, and I have done harm—harm to myself, and to others. I have used my prescription writing privileges to feed my own drug habit and feed my greed, selling dangerous drug prescriptions to drug pushers in exchange for cash, marijuana, or cocaine. I went through the motions of treating people who were not sick, just so I could get a paycheck from the clinic owners who didn't care—clinic owners who were using patients and using me as the practitioner so these clinic owners could steal.

It scares me to think of the harm done to those who might have gotten hooked on the drug prescriptions I wrote. It makes me ashamed to think that the money swindled from a righteous program, Medicaid, that is there to help this country's most needy and vulnerable people.

Mr. Chairman, your staff has kindly offered me the opportunity to shield my identity during my testimony. I have given this particular matter a lot of thought, and I have discussed it with my family. While I have found that openness has been the true road to rehabilitation for me, I have decided to go forward with this protection as it would be too painful to my family to reopen old wounds publicly. Even though there is a degree of anonymity, I do wish to be open and honest with you about all my involvement in this matter.

When I was growing up in the small town of Cairo, Georgia, I learned that the Scriptures say that the truth shall set you free, and now I know this to be true. I lived most of my adult life in denial and got lost in a world of drugs and luxury. I am here to answer your questions to the best of my ability, openly and honestly.

It has been said that the darkest hour is just before the dawn. My darkest hour began with my last arrest back in July 1991 and that dark hour dragged on for a long time. It wasn't over until I was in Terminal Island Federal Penitentiary, lying in a prison hospital bed nearly dying of lung disease. I was brought up in a very religious family, but I turned my back on the virtues they taught me many years ago. I believe that my greed and my over-inflated ego led me to abuse my position as a medical doctor. I still feel anguish when I think about how I let down my family, and I feel re-

sponsible for my mother having suffered a heart attack when I was there in the prison hospital.

The dawn came for me soon after that. While I was in prison on a Federal parole violation for writing illegal prescriptions, new criminal charges were filed against me in California State Court by the Attorney General's Office. The California Attorney General's Office has a unit known as the Bureau of Medi-Cal fraud. Medi-Cal is the same as Medicaid on the East Coast, I think. Their prosecutor, Mr. Hardy Gold, had filed charges against me for grand theft, Medicaid fraud, and illegally practicing medicine, as I had by that time lost my license due to my earlier misconduct. I wondered when I would ever be able to walk as a free man again.

The first rays of hope I had were when I was offered the opportunity to cooperate with the Medicaid Fraud Unit. The prosecutor and the Medicaid fraud investigators wanted my help to capture and convict others who used me and abused the Medicaid program. I reviewed the evidence that they had gathered by search warrants, I briefed them about the operation of this fraudulent clinic I was working at, and I did undercover work for them. This led to the conviction of others involved with the clinic. I also volunteered to share my insights into why some doctors and others in the medical field give in to the temptation to steal or abuse drugs.

This year I have been the featured speaker for three seminars for the State prosecutors and investigators of health care fraud, including a videotape made to train local law enforcement officers in other States. That video was shown as a training sponsored by the Drug Enforcement Administration. This is, of course, therapeutic for me and it allows me to try to return something to the community after having done so much damage when I was reckless and greedy.

When I speak about my past, I attempt to explain the mentality that leads health care professionals into crime. I also try to talk about the facts of the cases I have been involved with so that the listeners can see how easy it is to steal from Medicaid. Once we understand the temptation that is out there for the wayward professional person, and once we understand how easy it is to steal, then it becomes more clear what needs to be done to stop this type of crime.

This is a dangerous mind set that some doctors have. I call it the "God Complex." I know about this attitude because I had it myself. It started when I entered medical school at Emory. I left behind a very small town where virtually the only employment available when I was growing up was in the pickle, syrup and peanut factories, in tobacco farm labor, or working—as I had been doing—for my father's funeral home. I felt like I must be someone special to be chosen to go to medical school. My ego began to grow. While there I saw the miracles of modern medicine at work, and I used it to save people's lives. My ego grew even bigger.

As a student, intern, and resident, I worked incredibly long hours. I lost my fear of medicine in the process. It begins when the pharmaceutical companies give out their complimentary little black bags filled with samples, and I read about the drugs and experiment with them. The drugs kept me going and I didn't worry about addiction because I felt that I knew better than lay people. I took

them, they kept me going and I felt like I must be superman. That same attitude lead me to read about marijuana and assume that I could handle it too.

This arrogance, this so-called "God Complex," caught up with me in the 1978 period when I was enjoying making money in a successful practice in Alabama. I was arrested and convicted of trading prescriptions for marijuana cigarettes. I was sentenced to a minimum security facility that I called "Club Fed" because it was more like a country club than a prison. Obviously, it didn't deter me.

Though I lost my license in Alabama for that conviction, I was able to get licensed in California before the Alabama revocation was final. In California I got hooked on cocaine while an anesthesiology resident at a Los Angeles hospital. I left the residency program when my drug use began to interfere with the patient care.

I next began working at a prescription mill. These were so-called diet clinics which were really fronts for drug dealers who dealt in amphetamines. I was paid by the owners—- and these owners were not doctors—to write hundreds of controlled drug prescriptions, which they would take to a dirty pharmacy to fill. Everyone got what they wanted—junkies got drugs, clinic owners got money, and when they sold the drugs to junkies, the pharmacy owners got to bill Medicaid and got money from the clinic owners, and I got paid money and cocaine.

Eventually, my feeling of invulnerability led me to be careless, and I was arrested by a DEA sting operation. Like the time before in Alabama, I received special treatment. I was politely asked to come to the courthouse, and everything was very courteous and respectful. I was sentenced to Boron Federal Prison, another low security facility. This conviction resulted in the revocation of my California license.

When I got out of Boron, I was on parole. Eventually, I was offered the job of assisting a licensed physician at a clinic known as South Grand Medical Clinic in Orange County, California. When I got there, I realized this doctor—who I will call Dr. X—was not going to be practicing medicine there at all. Instead, this was just one of the several clinics that he was operating on paper, and I was the one who was going to treat the patients. Dr. X was not really the owner of these clinics. Instead, he was paid money for the use of his provider number by lay people who owned the clinics. By that I mean that Dr. X was an approved provider in the Medicaid program. So the South Grand Medical Clinic's owners paid him a monthly salary so that they could bill as though he was treating the patients. Dr. X prostituted his provider number and I practiced medicine without a license.

This arrangement suited the owners of South Grand just fine. When I say the owners, I mean a 22-year-old Cambodian young man called Rick Kheang, who claimed to be the owner, and his dad, who appeared to me to run the business from behind the scenes. What I saw was mainly Southeast Asian patients coming in by the van load to have me examine them and prescribe drugs to them under Dr. X's name. Only rarely did any of the patients ever appear to me to be sick, and then I am talking about nothing more serious than a cold. While it seemed suspicious, I didn't mind

since I was being paid $5,000 a month there. Only later when a patient asked me for money did I realize that the patients were coming into the clinic to get paid a kickback from Rick.

Mr. Gold prosecuted Rick and another 22-year-old Cambodian man who owned a local pharmacy known as Slamad Pharmacy. They were both convicted. He can explain the kickback arrangement between the clinic and the pharmacy, but I was just a player in this larger scheme. I wasn't told about the details of the owners' deal. In fact, it appeared to me that no one knew any more than they needed to know to do their job so that the Medicaid fraud could be perpetrated.

In July 1991 I was arrested after the California Medicaid Fraud Unit had done some undercover operations in the clinic and caught me prescribing illegally. This time it was quite different from before. They were in a task force with Federal agents and the State medical board. They all wore raid jackets, they seized evidence with a search warrant and I was handcuffed. I was treated as a common criminal. When I was convicted for violating my parole, I went to Terminal Island, and that was not "Club Fed." In conclusion, I want to say that most physicians do not fall prey to the "God Complex," but I did. I have seen many others go the same way. The temptation is out there and every opportunity is out there to steal and to do bad things to get a good life.

Since my release from prison, I have gone to the University of Southern California and obtained a master's degree in medical education so that even if I am never permitted to practice medicine again, perhaps I can help others by teaching. I have spoken to other physicians and educators to warn others about the path that I went down. I have volunteered my services on an ongoing basis to assist law enforcement. I have faced my past and commit myself every day to doing honest work and helping others.

I hope that my appearance here before you helps at least in some small way to improve the integrity of America's health care system, if only to show how vulnerable it is to abuse.

Thank you, Mr. Chairman.

[The prepared statement of Doctor B. follows:]

PREPARED STATEMENT OF DOCTOR B

I am a medical doctor who graduated from the prestigious medical school, Emory University, in Atlanta, Georgia. But I lost my privilege to practice medicine because I have stolen from Medicaid and wrote illegal prescriptions to junkies. I have been a healer who saved people's lives, and I have done harm: harm to myself, and to others. I have used my prescription writing privileges to feed my own drug habit and feed my greed, selling dangerous drug prescriptions to drug pushers in exchange for cash, marijuana or cocaine. I went through the motions of treating people who were not sick, just so I could get a paycheck from clinic owners who didn't care: clinic owners who were using the patients and using me as the practitioner, so these clinic owners could steal.

It scares me to think of the harm done to those who might have gotten hooked on the drug prescriptions I wrote. It makes me ashamed to think of the money swindled from a righteous program, Medicaid, that is there to help this country's most needy and vulnerable people.

Mr. Chairman, your committee staff has kindly offered me the opportunity to shield my identity during my testimony. I have given this particular matter a lot of thought and I've discussed it with my family. While I have found that openness has been the true road to rehabilitation for me, I have decided to go forward with this protection as it would be too painful to my family to reopen old wounds publicly. Even though there is a degree of anonymity, I do wish to be open and honest

with you about all of my involvement in this matter. When I was growing up in the small town of Cairo, Georgia, I learned the scriptures say that the truth shall set you free. Now I know this to be true. I lived most of my adult life in denial and got lost in a world of drugs and luxury. I am here to answer your questions to the best of my ability, openly and honestly.

It has been said that the darkest hour is just before the dawn. My darkest hour began with my last arrest, back in July 1991, and that dark hour dragged on for a long time. It wasn't over until after I was in Terminal Island Federal Penitentiary, lying in a prison hospital bed nearly dying of lung disease. I was alone, weak, in pain, a disgrace to my family and myself. I was brought up in a very religious family, but I turned my back on the virtues they taught me many years ago. I believe that my greed and my over-inflated ego led me to abuse my position as a medical doctor. I still feel anguish when I think about how I let down my family and I feel responsible for my mother having suffered a heart attack when I was there in the prison hospital.

The dawn came for me soon after that. While I was in prison on a Federal parole violation for writing illegal prescriptions, new criminal charges were filed against me in California State Court by the Attorney General's office. The California Attorney General's office has a unit known as the Bureau of Medi-Cal Fraud. Their prosecutor, Mr. Hardy Gold, had filed charges against me for grand theft, Medicaid fraud, and illegally practicing medicine, as I had by that time lost my license due to my earlier misconduct. I wondered when I would ever be able to walk as a free man again. The first rays of hope I had were when I was offered the opportunity to cooperate with the Medicaid Fraud Unit. The prosecutor and the Medicaid fraud investigators wanted my help to capture and convict others who used me and abused the Medicaid program. I reviewed evidence that they had gathered by search warrants, I briefed them about the operation of this fraudulent clinic I was working at, and I did undercover work for them. This led to the conviction of the others involved with the clinic. I also volunteered to share my insights into why some doctors and others in the medical field give in to the temptation to steal or abuse drugs. This year I have been the featured speaker for three seminars for State prosecutors and investigators of health care fraud, including a videotape made to train local law enforcement officers in other States. That video was shown at a training sponsored by the Drug Enforcement Administration. This is therapeutic for me and it allows me to try to return something to the community after having done so much damage when I was reckless and greedy.

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ers—and these owners were not doctors—to write hundreds of controlled drug prescriptions which they would take to a dirty pharmacy to fill. Everyone got what they wanted: junkies got drugs, the clinic owners got money when they sold the drugs to junkies, the pharmacy owners got to bill Medicaid and got money from the clinic owners, and I got paid money and cocaine.

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In conclusion I want to say that most physicians do not fall prey to the "God Complex," but I did. I have seen many others go the same way. The temptation is out there and the opportunity is out there to steal and to do bad things to get the good life. Since my release from prison I have gone to the University of Southern California and obtained a masters degree in medical education so that even if I am never permitted to practice medicine again, perhaps I can help others by teaching. I have spoken to other physicians and educators to warn others about the path that I went down. I have volunteered my services on an ongoing basis to assist law enforcement. I have faced my past and commit myself every day to doing honest work and helping others. I hope that my appearance here before you has helped at least in some small way to improve the integrity of America's health care system, if only to show how vulnerable it is to abuse.

Thank you.

The CHAIRMAN. Thank you very much, Doctor B.

Ms. Brambila.

STATEMENT OF KRISTINA ROWLAND BRAMBILA, HEALTH CARE FRAUD VIOLATOR

Ms. BRAMBILA. My name is Kristina Rowland Brambila——

The CHAIRMAN. Before you begin, Senator Burns, do you have a statement that you would like to make?

Senator BURNS. I would just say, Mr. Chairman, thank you for this timely hearing and there is no doubt that we do have fraud and abuse, and it's costing all of us, especially those in Montana. If you just look at the situation with our budget and everything else, you know, if we could cure this end of Medicare, we could cure the big end of our funding for Medicare.

So I just have a formal statement, and with your permission, I would like to enter it in the record, and I thank you for holding these hearings.

The CHAIRMAN. Without objection, your prepared statement will appear in the record.

[The prepared statement of Senator Burns follows:]

PREPARED STATEMENT OF SENATOR BURNS

Mr. Chairman, thank you for holding this hearing. We have focused on Medicare fraud in the past and it never ceases to amaze me to hear the amount and type of fraud that continues to go on. As we are fighting to control the budget, fighting to save Medicare and Medicaid, it seems even more important that we make every effort to reduce and, if possible, to eliminate fraud and abuse in these programs.

I am looking forward to hearing from our witnesses today. I think it's important that we know just how easy it is to abuse Medicare. I'll be even more interested to know what we could have done that would have prevented them from violating the law. Stricter penalties? More enforcement? Make access more difficult?

The crimes you have all been convicted of are serious and, no doubt, you thought you could get away with it or you thought the benefits outweighed the consequences. We truly need your help in finding ways to prevent this. We are losing billions of dollars each year, dollars that could be spent healing or preventing disease. These dollars don't just come from some great big coffer in the sky called the Federal Government—these are dollars collected from taxpayers. My dollars, your dollars, my neighbors dollars, and the dollars of our parents and children * * * all being wasted.

Mr. Chairman, in last week's hearing I stated that Montana has so little fraud and abuse that the Inspector General has assigned no investigators to our State. That's true, but I did happen upon an article last Friday that revealed a Montana facility overcharged Medicaid nearly a quarter of a million dollars. Though Justice Department officials were very quick to point out that there was no criminal intent to defraud the State, it still points out a weakness in the system.

Medicaid is one program that drives the State's budget, particularly in Montana. If indeed, the facility was overpaid, that $249,000 could have gone to serve hundreds of Montanans in need.

We have the Inspector General and her team dedicated to finding and stopping fraud and abuse in these programs. We also have the FBI assigning Special Agents to health care fraud squads in major metropolitan areas. We have States dedicating funds to investigating fraud. Are these fraud violators that hard to catch? Perhaps Ms. Jaggar will be able to answer a question—is the amount of money we spend on investigating fraud and abuse directly proportionate to the amount of money we retrieve from the violators?

I think much of our problem stems from education. Being aware, knowing your benefits, knowing what is being billed, and not being afraid to question, and, though this sounds sad, not trusting blindly. Fraud does not just take place through doctors billing false claims. It happens with durable medical equipment being sold to beneficiaries who don't need it. It happens when telemarketers hard-sell trusting seniors to undergo tests "for free." It happens when kickbacks are offered for steering business to a particular supplier or lab or pharmacy.

It really is widespread and I think we need to couple our efforts with an effort to make people aware. Some of our first panel was caught only because of smart consumers—not because our system worked, but because someone scrutinized their bill or questioned a provider and then turned them in. That kind of cooperation will aid us immeasurably.

Mr. Chairman, you and your committee staff produced a very important report last year entitled "Gaming the Health Care System." In it you recommend tougher criminal penalties, establishing a national health care fraud database, designing a uniform claim form, and controlling provider numbers. I believe all these would help reduce fraud and I am interested to know from our first panel whether, if any of

these recommendations had been in effect, they would have been deterred from every starting a fraudulent practice.

No one doubts that fraud and abuse are costing Americans dearly. Montanans, whether fraud is prevalent in my State or not, pay for the fraud and abuse all across the Nation. We just can't afford it. It is not just bad for our economic health, it is bad for the health of our seniors. When we are losing $100 billion each year on health care fraud, we are losing vital health care services for those who truly need them.

I commend you, Mr. Chairman, for your dedication in pursuing this issue. I support you and your efforts to make fraud and abuse a thing of the past.

The CHAIRMAN. Ms. Brambila.

Ms. BRAMBILA. My name is Kristina Rowland Brambila. I am testifying before you today because I participated in a criminal scheme that caused the loss of millions of Medicare program dollars.

In 1993 I plead guilty to an 11-count criminal indictment, charging me with conspiracy and mail fraud for my role in a scheme that defrauded the Medicare program of about $7 million. I want to tell you how I successfully defrauded the Medicare program so that you can learn how vulnerable the current system is to fraud and abuse.

I apologize for being somewhat underdressed for this occasion, but I was only released from Federal custody 2 weeks ago, after serving a 37-month sentence for my part in this Medicare billing fraud. These are the best clothes that I own at this time. My criminal behavior and my subsequent incarceration has caused such a disintegration in my life that it should be apparent to all that the mistake I made will follow me forever. What you need to know is that I am not alone in stealing from Medicare. There are too many others out there committing health care fraud on a scale that you cannot even begin to conceive.

Let me tell you how easy it was for me to bill Medicare falsely for surgical dressings for patients who never had surgery. It helps to have a background in health care. Since about 1970 I have worked in various areas of geriatric care in over 250 nursing homes as an employee and/or consultant in 28 States throughout this country. I have worked in billings, medical records, and other administrative areas, starting out at the bottom as a ward clerk. My work experience includes having worked with and/or for some of the largest health care companies that provide services to the elderly, and theoretically some of the most reputable companies.

I was able to use this experience when in the spring of 1990 my sister told me that she desperately needed some money to pay bills and asked if I knew of a way for her to get a lot of money. I told her that you could make lots of money for billing Medicare for services that were not provided as claimed, as I had seen it done in many large health care companies that I knew over the years. Because of my background in health care delivery, I knew that if you use the right words and the codes on the claims, it is very difficult for the Medicare program to catch false claims at the time that they are submitted.

Having my own established health care company and developed and managed skilled nursing facilities and other health care entities, we then started through "Handled With Care," my company, which conducted what we called "lost charge audits." I first went to a nursing home in the Seattle area and explained that because of my background, I could recover money for them by auditing the

facility's medical records against claims the nursing home had previously submitted. Then I would bill Medicare for anything found in the medical records that the nursing home had overlooked. My company would take a percentage of the payments received from Medicare for these claims, and if we received no payment, they need not pay us.

I knew that the nursing home had not billed for bandages and dressings because they are usually considered routine costs that are included in the daily rate that Medicare pays to the facility. Surgical dressings are an exception to this rule. It is rare for nursing homes to provide surgical dressings because few nursing home patients have surgery while in the nursing home. However, if a patient has received surgery and a surgical dressing is provided, it can be billed to Medicare legally.

It was easy to take advantage of this exception by preparing and submitting to Medicare claims for surgical dressings, which falsely represented that the beneficiary was receiving post-surgical care. In truth, no surgery had occurred. In addition to falsifying the claims, we significantly inflated the charges for these dressings. These dressings consisted of no more than a 4 by 4 gauze pad that costs less than a penny when bought in bulk. We charged Medicare, and were paid between $5 to $7 for each dressing.

It took a couple of weeks to prepare and submit the claims to Medicare, but within 2 months the nursing home was paid approximately $600,000 by Medicare for these false claims. The next nursing home for which we conducted a lost charge audit was in the San Francisco Bay area. The "audit" was identical to the one we did in Seattle and Medicare paid another $600,000 for these false claims.

Although we did not directly tell the nursing homes we were submitting false claims, they should have been suspicious and questioned the claims and charges that we submitted. Had they merely glanced at their copies of the claims, they would have immediately noted how exorbitant the charges were compared to the actual cost of the bandages. They also could have readily checked the facility's records to verify that the patient identified on the claim had undergone surgery. Instead, every nursing home with which we dealt gleefully took the money and told other nursing home administrators of our service—even collecting finders fees from other facilities for their referring them to us. No one questioned anything.

One nursing home was so pleased they introduced us to a major Washington, D.C. health care law firm, which became a major investor in "Handled With Care," and with the law firm's financial backing, we rapidly expanded our scheme. We hired about 80 people, had an annual payroll of almost $1 million and expanded into 9 States where we conducted "lost charge audits" for over 70 nursing homes in less than a year.

I want to make it clear, however, that apart from my sister and I, none of the employees of Handled With Care were aware of the fraudulent nature of any of these claims. This was due to the fact that my sister and I were the only two to place the fraudulent diagnosis codes on the claims that were submitted to Medicare for payment.

In April 1992 my sister and I were indicted by the U.S. Attorney for the Northern District of California for conspiracy and mail fraud. The charges related to the second nursing home where we had conducted the lost charge audit. I plead guilty to all charges and testified against my sister at her trial. As you can imagine that was not an easy thing to do, and it has literally destroyed my relations with my family—something that I can never rebuild. My sister is still serving her 5-year sentence.

Medicare only uncovered our scheme by performing a routine, random audit of nursing home claims—literally by accident. Blue Cross of California, the Medicare intermediary, had asked the nursing home in San Francisco for information about the surgery referenced on a claim that we had prepared the bill for surgical dressings. The nursing home quickly discovered that the patient in question had never had surgery. They then discovered that none of the patients for which "Handled With Care" billed had ever had surgery as claimed. The nursing home then contacted the Office of the Inspector General for the Department of Health and Human Services, whose investigation led to my sister's and my subsequent arrest, conviction, and prison terms.

It is easier than you can possibly imagine to prepare false claims and have them paid by Medicare. Because of the huge volume of claims that Medicare processes and the lack of adequate safeguards built into the system, the chance of a fraudulent claim being caught during the processing in my opinion is slim and none—and believe me, I know. As long as the numbers are right and information passes the scanners and edits, Medicare's computers just pass the claim through the system and make payment. I can tell you that there are many individuals and large scale health care corporations of some repute which know how Medicare's computers screen the claims and how to circumvent these edits and are doing it every day in almost every State in this country.

It's not a question of whether fraud is being committed in facilities—it's a question of how much fraud is being committed in each facility. Even though I am responsible for major fraud against the Medicare program and its beneficiaries, I know—I have seen—there are many other people out there committing far greater fraud as I speak. This is just the tip of the iceberg, and I'm not even sure it's the tip. I've seen them at work, I know the problem is vast and growing and I see it going without any check whatsoever.

Based on my 20 years of experience in this industry, I believe that many, if not most, of the medical supplies that Medicare pays vendors to provide in nursing homes and home health care agencies have not been ordered by a physician and may not have ever been used by the patient. There is rarely any medical necessity for these supplies, and Medicare is wasting millions of dollars.

Part of the problem, which I took advantage of, is the lack of accountability. There is something wrong with a system when a nursing home patient in California can receive supplies from a medical supply company in New Jersey that bills these supplies through a Medicare intermediary in Illinois. As crazy as that may sound, that is exactly how your system works—with no accountability. There are no checks possible as the system now exists. You have literally

given unscrupulous health care providers and suppliers a blank check that could easily and rapidly bankrupt the system.

In my opinion, Medicare needs to do more random audits of nursing homes records. Physicians need to be required to certify the medical necessity of supplies and be held liable for falsely signing these certifications which happens everyday. The Medicare intermediary needs to randomly review these certifications. There needs to be more onsite audits at nursing homes and the associated suppliers. These audits must look at source documentation like invoices for supplies to show actual purchase of the supplies and actual costs, and documentation that the services actually were rendered and needed instead of taking everything on good faith.

As I took advantage of that good faith, there are many others right this minute who are taking advantage of Medicare. The honor system does not work for those without honor. Money spent needs to be focused on the actual workings of how this fraud can be perpetrated, and more agents and agents with better training that know the interworkings of the facilities and how these things can actually happen need to be instituted.

I appreciate the opportunity to be able to speak to you, and be able to hopefully help in any way I can to see that this ends because it's not the end, and as a person who is of the baby-boomer generation, Medicare won't be there when I get there if something isn't done.

This concludes my prepared statement, and I will try to answer any questions you may have of me.

Thank you.

[The prepared statement of Ms. Brambila follows:]

PREPARED STATEMENT OF KRISTINA ROWLAND BRAMBILA

My name is Kristina Rowland Brambila. I am testifying before you today because I participated in a criminal scheme that caused the loss of millions of Medicare program dollars. In 1993, I pled guilty to an eleven count criminal indictment, charging me with conspiracy and mail fraud for my role in a scheme that defrauded the Medicare program of about $7 million. I want to tell you how I successfully defrauded the Medicare program so you can learn how vulnerable the current system is to fraud and abuse.

I apologize for being somewhat underdressed for this occasion, but I was only released from Federal custody 2 weeks ago, after serving a 37 month sentence for my part in this Medicare billing fraud. These are the best clothes I own. My criminal behavior and my subsequent incarceration has caused such a disintegration in my life that it should be apparent to all that the mistake that I made will follow me forever. What you need to know is that I am not alone in stealing from Medicare. There are too many others out there committing health care fraud on a scale you can not begin to conceive.

Let me tell you how easy it was for me to bill Medicare falsely for surgical dressings for patients who never had surgery. It helps to have a background in health care. Since about 1970 I have worked in various areas of geriatric care in over 250 nursing homes as an employee and/or consultant. I have worked in billings, medical records and other administrative areas. My work experience includes having worked for some of the largest health care companies that provide services to the elderly.

I was able to use this experience when, in the spring of 1990, my sister told me she needed money to pay her bills and asked if I knew a way to get a lot of money. I told her that you could make lots of money by billing Medicare for service that were not provided as claimed. Because of my background in health care delivery, I knew that, if you use the right words and codes on the claims, it is very difficult for the Medicare program to catch false claims at the time they are submitted.

In order to implement this billing scheme, we started a company called "Handled With Care" which conducted what we called "lost charge audits". I first went to a

nursing home in the Seattle area and explained that because of my background, I could recover money for them by auditing the facility's medical records against claims the nursing home had previously submitted. Then I would bill Medicare for anything found in the medical records that the nursing home had overlooked. My company would take a percentage of the payments received from Medicare for these claims.

I knew that the nursing home had not billed for bandages and dressings because they are considered routine costs that are included in the daily rate Medicare pays to the facility. Surgical dressings are an exception to this rule. It is rare for nursing homes to provide surgical dressings because few nursing home patients have surgery while in the nursing home. However, if a patient has received surgery and a surgical dressing is provided, it can be billed to Medicare.

My company took advantage of this exception by preparing and submitting to Medicare claims for surgical dressings which falsely represented that the beneficiary was receiving post-surgical care. In truth, no surgery had occurred. In addition to falsifying the claim, we significantly inflated the charges for these dressings. These dressings consisted of no more than a 4x4 gauze pad that costs less than a penny when bought in bulk. We charged Medicare, and were paid, between $5–7 for each dressing.

It took a couple of weeks to prepare and submit the claims to Medicare. Within 2 months, the nursing home was paid approximately $600,000 by Medicare for these false claims. The next nursing home for which we conducted a lost charge audit was in the San Francisco Bay Area. The "audit" was identical to the one we did in Seattle and Medicare paid another $600,000 for these false claims.

Although we did not tell the nursing homes we were submitting false claims, they should have been suspicious and questioned the claims and charges we submitted. Had they merely glanced at the claims, they would have immediately noted how exorbitant the charges were compared to the actual cost of bandages. They also could have readily checked the facility's records to verify that the patient identified on the claim had undergone surgery. Instead, every nursing home with which we dealt gleefully took the money and told other nursing home administrators of our service.

One nursing home was so pleased they introduced us to Washington, DC health care law firm, which became a major investor in "Handled With Care." With the law firm's financial backing, my sister and I rapidly expanded our scheme. We hired about 80 people, had an annual payroll of almost $1 million and expanded into nine States where we conducting "lost charge audits" for about 70 nursing homes. I want it clear, however, that apart from my sister and I, none of the employees of the Handled with Care were aware of the fraudulent nature of the claims. This was due to the fact that my sister and I were the only two to place the false diagnosis code on the claims submitted to Medicare.

In April 1992 my sister and I were indicted by the U.S. Attorney for the Northern District of California for conspiracy and mail fraud. The charges related to the second nursing home where we had conducted the lost charge audit. I pled guilty to all charges and testified against my sister at her trial. As you can imagine that was not an easy thing to do and literally has destroyed my relations with my family. My sister is still serving her 5 year sentence.

Medicare uncovered our scheme by performing a routine random audit of nursing home claims. Blue Cross of California, the Medicare intermediary, asked the nursing home in San Francisco for information about the surgery referenced in the claim I had prepared for the surgical dressings. The nursing home quickly discovered that the patient in question never had surgery. They then discovered that *none* of the patients for which "Handled with Care" billed had ever had surgery as claimed. The nursing home contacted the Office of Inspector General for the Department of Health and Human Services, whose investigation led to my sister's and my subsequent arrest, conviction and prison terms.

It is easier than you can imagine to prepare false claims and have them paid by Medicare. This is because of the huge volume of claims Medicare processes and the lack of adequate safeguards build into the system. The chance of a fraudulent claim being caught during the processing of a claim in my opinion is slim and none.

As long as the numbers are right and information passes the scanners and edits, Medicare's computers just pass the claim through the system and makes payment. I can tell you that there are many individuals and large scale enterprises which know how Medicare's computers screen claims and how to circumvent these edits.

Even though I am responsible for a major fraud against the Medicare program and its beneficiaries, there are many other people out there committing far greater fraud as I speak. I have seen them at work and know the problem is vast and growing. Based on my 20 years of experience in this industry, I believe that many, if not most, of the medical supplies Medicare pays vendors to provide in nursing

homes and home health agencies have not been ordered by a physician and may not have been used by patient. There is rarely any medical necessity for these supplies and Medicare is wasting millions of dollars.

Part of the problem, which I took advantage of, is the lack of accountability. Something is wrong with a system when a nursing home patient in California can receive supplies from a company in New Jersey that bills these supplies through a Medicare Intermediary in Illinois. As crazy as that may sound that is exactly how the system works * * * with no accountability. There are no checks possible as the system now exists. You have given unscrupulous health care providers and suppliers a blank check.

In my opinion, Medicare needs to do more random audits of nursing homes records. Physicians need to certify the medical necessity of supplies and be held liable for falsely signing these certifications. The Medicare intermediary needs to randomly review these certifications. There needs to be more onsite audits at nursing homes and the associated suppliers. These audits must look at source documentation like invoices and documentation that the services actually were rendered. Instead of taking everything on good faith. I took advantage of that good faith and there are many others right this minute who are taking advantage of Medicare.

This concludes my prepared statement and I will try to answer any questions you may have of me.

The CHAIRMAN. Thank you very much, Ms. Brambila.

You did not mention the prospect of increasing penalties for each of the fraudulent activities that take place. I was wondering if that was one of the recommendations that you might make.

Ms. BRAMBILA. I not only would do that, but what I would do more than anything else is you have a law that you enacted in Congress in I believe 1987, the OBRA law, in which you stiffened many of the regulations for a more uniform, regulatory process throughout the country. In that law there are documentation provisions which could then be implemented and changed in a simple way to where it would give a greater degree of accountability, and it would put people in a position of showing that they knowingly defrauded the government. There are few checks. There is no way to track these things, and many times I find supplies billed for that never—the people never even bought them, let alone sent them to the patient.

The CHAIRMAN. Well, we won't get into a debate this morning about the virtues of the Senate bill over the House bill other than pointing out perhaps that under the Senate version we do not require, as the House does, that a show of reckless disregard for the truth of the billing be submitted to Medicare. We apply a much easier standard for prosecutors that there should be a good faith effort on the part of the doctors to exercise due diligence and to in fact review what is being submitted and why it is being submitted, but that's for another day of debate.

Let me turn to witness A. You indicated that you had completed a prison sentence and then opened up a nightclub operation prior to your becoming involved in the home health care field.

Mr. A. I used to have a nightclub, then I went to prison, then I came home, then I got into the home health care field.

The CHAIRMAN. So it's the nightclub first, then prison, then you came out and then got into the home health care field?

Mr. A. Yes.

The CHAIRMAN. All right, now you said that your problems began when you started to bill Medicare electronically, that Medicare didn't require you to submit any of the backup paperwork that might be necessary. At the time did you have any concern that Medicare might say, Mr. A, where is the real stuff, where is the

backup material that would justify your submitting this electronically? Was there any fear or apprehension on your part that Medicare might insist upon backup information?

Mr. A. No, sir.

The CHAIRMAN. Do you know people in the community that you dealt with who operated similar types of home health care operations? Do they have any fear that they would have to come up with any sort of substantiation as far as the records were concerned?

Mr. A. I can't really speak for other home health care agencies.

The CHAIRMAN. Just your own?

Mr. A. Yes, I can only speak for mine.

The CHAIRMAN. You said that there were times when Medicare denied claims because they questioned the bills you submitted but they paid them anyway?

Mr. A. Yes.

The CHAIRMAN. Sort of like we'll shoot now and ask questions later?

Mr. A. Yes.

The CHAIRMAN. We'll pay you now and we'll ask questions later?

Mr. A. That's correct.

The CHAIRMAN. When they asked you questions later, did anything come of that?

Mr. A. Well, for example, you sent a bill in for $100,000 and then they later ask you for 10 percent of that. So they're only asking for $10,000 for bills. They don't ever ask for 100 percent unless they feel that you're defrauding the government.

The CHAIRMAN. In other words, if they saw a questionable claim that you had submitted for $100,000 and they went back and asked you to re-examine that, you would simply give them $10,000 of the $100,000 they had paid?

Mr. A. Yes.

The CHAIRMAN. So they just knocked off 10 percent and that was it?

Mr. A. That's correct.

The CHAIRMAN. Do you think that patients ought to be provided with what they call an EOB, an Explanation of Benefits, for home health care services?

Mr. A. Yes.

The CHAIRMAN. They're not provided now, are they?

Mr. A. No.

The CHAIRMAN. Except if there is a doctor's visit.

Mr. A. That's correct, and a lot of times they don't receive the doctor's order that is given to the home health care agency.

The CHAIRMAN. So someone who receives home health care has no idea what you are billing the Medicare system for?

Mr. A. No.

The CHAIRMAN. There is no way of knowing? It could have a $10,000 claim or $100,000 claim? Whatever the amount is, they never see this unless, what, unless there is a question that is directed—unless Medicare finds some reason to question the billing? Do they then go to the Medicare beneficiary and say, "Were you aware of these charges?"

Mr. A. Yes.

The CHAIRMAN. Is that the time that they go to them?

Mr. A. Yes.

The CHAIRMAN. Now you did indicate you talked to some nice ladies at Blue Cross who questioned why you were billing Medicare for home health care services given to dead people?

Mr. A. Yes.

The CHAIRMAN. You just told them it's a mistake?

Mr. A. Yes.

The CHAIRMAN. What happened?

Mr. A. We told them it was a mistake, and we told them to credit the money that was accidentally billed. So we billed for five dead people a total of $20,000, and they owed us $300,000 on the 15th so they just subtracted the $20,000 from the $300,000.

The CHAIRMAN. Did they ever—well, let me go on. Were they asking enough information from you to track down discrepancies in your billing, in your notes? Did they ever ask for more information so they could verify what you were billing for and what was actually being delivered?

Mr. A. Later they did. About 2 or 3 months before I closed they began to ask for 20 percent, 30 percent, 50 percent, 70 percent. They wanted to see almost 100 percent—by the time I got ready to close in August they wanted to see 100 percent of everything that we billed for to make a determination if everyone needed the services at that time.

The CHAIRMAN. Did the physicians who signed the orders for the need for home health care ever check to see if the patients were either sick or home bound?

Mr. A. I cannot agree that they checked to see if they were home bound, but they did write up an order to determine if they were sick and needed the services. I really don't think that a lot of the physicians understand when a person should receive home care. They just think that if a person is sick, you go to see them—they don't have to come to me, or we don't have to admit them to the hospital, or they go to see them after they have been discharged from the hospital to make sure that they're OK and I don't have to see them. I don't really think that the physicians understand the definition of—what the purpose of home care is.

The CHAIRMAN. Basically, then you would go to the physician to get them to sign the orders saying we are preparing to take care of this individual who may have been hospitalized?

Mr. A. No, the physician may call us and say, "Listen, I have a patient that's going to be discharged tomorrow. I need you to send a nurse out there to determine how much home care services that they're going to need and how long." We might say they need to be seen for 3 months, and he signs the order for 3 months but he never goes out himself to determine if the patient actually needs to be seen for 3 months.

The CHAIRMAN. We have some patient home health notes, which were obtained during a search warrant of your business and there were 38 patient files that had been created with notes signed by one particular home health aide, and the Federal investigator of your case stated the aide never saw any of these patients, didn't sign the notes. In fact, the aide lived 120 miles away in the desert. The Federal investigator also stated that 260 of the patients for

which Medicare was billed had no medical file at all. Some of the patients were just made up names, right? Are you familiar with that?

Mr. A. Yes, I guess. I wasn't aware of that.

The CHAIRMAN. You're not aware of that. We also have some nursing notes for a particular patient that were obtained during the same search warrant for your business. Blue Cross had flagged a beneficiary's notes for medical review. This beneficiary had 123 visits billed in her name, over $13,000 paid and she never had any home health care at all. Her physician's name was forged on the Plan of Treatment and her social security number was obtained when she was visited by your company's marketing individual. Are you familiar with that information?

Mr. A. No, I would like to explain my position. I was the administrator. I set up the company, then I had a director, nurses, and an assistant administrator to work under me. I knew nothing about nursing. So if I hired a director, nurses, and pay her $80,000, she hires all the aides, all the nurses. So if she would send them out three times a week, or ten times a week, or tell them to sign the patient names, that is something that I have no knowledge of because I did not know nursing.

The CHAIRMAN. So, in other words, you're just a business administrator? The Federal authorities decided that since you could run a nightclub, you were then qualified to run a home health care agency?

Mr. A. That's correct, and I think that was ridiculous, but I was surprised and happy that I was able to be in that position. I later than spoke to the agent and I explained to them that if they had done a background check on me or asked me—first of all, they never asked for identification. They didn't even know my real name was the name that I put on the application. They did not ask you for a picture identification, they did not ask you for your social security number, they did not ask you for a fingerprint. I think that these are things that need to be done so they can determine that the person that is applying for the license is the person that you're actually giving the license to, to allow them to bill for millions of dollars. You don't even know if this is the person or not.

The CHAIRMAN. It would be fair to say that it's probably easier to get a license or to be certified to operate a home health care agency than it is to get a credit card?

Mr. A. Very easy because they don't do a background check. They don't ask for any information. If you say my name is John Doe, OK, your name is John Doe. They give you a license, they give you a provider number, you bill and that's it. It's simple, easy. I mean, they make it too easy for any one to go into this business.

The CHAIRMAN. Senator Pryor.

OPENING STATEMENT OF SENATOR DAVID PRYOR

Senator PRYOR. Well, it appears, Mr. Chairman, and I think this hearing is confirming some of our worst fears—that we have created an open money sack and there are a lot of people who know how to get into that money sack. People like the witnesses have figured it out and have become professionals at it.

My question is if you were setting up another company and your intent was to defraud the government or to defraud a private health care insurer, would it be easier to set up a company to defraud a private health care insurer or easier to defraud a government program? Which would be least likely to detect your fraudulent billing?

Mr. A. I would have to say it would be easier to go into the Medicare business if I want to—say, I want to go into this business with the intent to defraud the government. If that was my intent, it would be very easy to do that. All you would have to do is—you don't have to go get a fake identification, you don't have to do nothing. You just say my name is this, they don't ask for a social security number——

Senator PRYOR. May I ask the question to Witness B, please. Would it be easier to defraud a private insurer or a government program?

Doctor B. I think the government would be much easier because in the private sector, you will have much more scrutiny because if you defraud them, they are protecting their interest. They have more of a vested interest in remaining solvent. So they protect their interest much more readily I think than the government because it's mostly dedicated down the totem pole type of scrutiny and it loses its impact as you go farther away from the top.

Senator PRYOR. I wonder if we may pose that same question to——

The CHAIRMAN. If you would just yield on that point.

Senator PRYOR. Sure.

The CHAIRMAN. By the same token, Mr. A. indicated that he had a visit from some nice ladies from Blue Cross/Blue Shield who questioned why he was billing for dead people and—excuse me.

Mr. A. Well, there wasn't any visits from Medicare. There was a phone call.

The CHAIRMAN. A phone call.

Mr. A. There was a phone call asking us——

The CHAIRMAN. So they called you?

Mr. A. Yes, they said, "Listen, we understand we got a couple of people—oh, do we? Oh, no, it must be a mistake. No, she didn't know what she was doing. She made a mistake. She's a Mexican girl and she can't speak English. Would you disregard that? OK, we will credit you."

The CHAIRMAN. So the private sector is not exactly putting up walls either.

Senator PRYOR. Right. Did we ask you the question? Would you rather try to defraud a private or a government program?

Ms. BRAMBILA. If I had a scale of 1 to 10 and I could rate them, I would rate the government about a 35 and I would give the private sector about a 2. In other words, it is so much easier because having been in this business as long as I have, all I have seen Medicare do is decrease the surveillance. In the 1960's when I first went into this business and Medicare had just started, we had utilization of analysts that came out onsite, went into the facilities, and looked at what was actually going on. As the dollars for processing got less and payment got higher, something got lost in the translation.

Senator PRYOR. You know, I was just reading the clips this morning from the Arkansas Democrat Gazette, and there has been an ongoing case down there that is of some interest——

The CHAIRMAN. Do they have an Arkansas Republican Gazette too? [Laughter.]

Senator PRYOR. Well, I will tell you, the Democrat Gazette—a lot of people think it is Republican, I might say. [Laughter.]

A local taxi cab company—and mind you, we have 2.5 million people in the whole State—a local taxi cab company in Little Rock has billed $2.5 million to Medicare for transporting Medicare patients to doctors and to hospitals. Someone figured out that that would be about 28 cab rides per month for every one in the city of Little Rock, Arkansas, if they did all they say they did. So there, again, the open money sack is once again there, and people sense it and are lured to it.

The CHAIRMAN. If you would yield further, I would point out that the so-called taxi cab rides are actually being billed as ambulance rides, reimbursed for ambulance service, not taxi cab rides to the clinics. That's another facet in this particular problem.

Senator PRYOR. I'll tell you what, Mr. Chairman. If the three of our witnesses were a United States Senator or Congressman and wanted to plug up these loopholes, wanted to absolutely make sure that this would not be repeated again, how would they strengthen the present rules and regulations and laws? I would very much like for you all to reflect on that. Perhaps you could submit your answers for the hearing record before we close it out. I would be indebted if you would.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Pryor.

[The prepared statement of Senator Pryor follows:]

PREPARED STATEMENT OF SENATOR PRYOR

Mr. Chairman, there are too many examples of fraud in our health care system. We will hear three such examples during the first panel of this hearing. I've reviewed the witnesses' testimony. From what I read, it appears to me that our first panel will have more stories of greed, more stories of personal tragedy, and more stories of betrayal than the average soap opera. What we need to bear in mind is that in addition to hurting themselves, these individuals—and every other individual who takes part in health care fraud—is hurting many others.

Mr. Chairman, health care fraud and abuse in our health care system is draining billions of dollars a year from American families, businesses, and government. Every dollar stolen from the health care system—be it from Medicare, Medicaid, or a private health care plan—means one less dollar for patient care or for lower insurance premiums. With health care costs still escalating, the last thing we need to be doing is allowing criminals and opportunists to steal precious resources from the system. Fraud also tarnishes the good names of honest health care professionals and companies. While the vast majority of providers are honest and hard working, the crooks cast a cloud over the entire health care system.

Much studying has been done on the health care fraud and abuse problem in recent years. In addition to the report issued last year by Senator Cohen, reports by the General Accounting Office, the HHS Inspector General, and Congressional Committees (including this panel) have also documented the extent and range of the problem. They have detailed abuses ranging from the billing of services never provided to the illegal sale of controlled substances. What these reports have in common is the conclusion that billions of dollars are lost each year to fraud and abuse.

Let me now talk about some positive things going on in this area. As we hear today about the countless scams against government and private health insurance plans, it is important to bear in mind that there are professionals in the private and public sectors making courageous and, in many cases, substantive, efforts to combat these problems. I am particularly impressed with the work of June Gibbs

Brown, the Inspector General of the Department of Health and Human Services. As Inspector General of HHS, she is responsible for overseeing some of the most expensive Federal programs, such as Medicaid and Medicare.

Mr. Chairman, I look forward to hearing the testimony of our witnesses.

Before yielding to Senator Burns, when I mentioned Blue Cross/Blue Shield, they are serving as an intermediary in this particular case on behalf of the Federal Government, but the point was that even though you have private sector involvement, there is not nearly enough scrutiny in the processing of claims ultimately paid by the Federal Government.

Senator Burns.

Senator BURNS. Thank you, Mr. Chairman.

I want to ask Witness A. when you opened your business and were certified by Medicare, was there a physical opening audit on your business? In other words, did you have the capital to go into business and were you bonded because you're going to handle other people's funds? Was there any requirement or an opening audit that you're qualified to do this?

Mr. A. No, you have to have the capital to go into the business, but you were not asked to have a bond.

Senator BURNS. Were you ever audited by Medicare during or while you were in business, like a yearly audit?

Mr. A. No, sir.

Senator BURNS. I guess I can't believe that as many dollars as Medicare handles that there wouldn't be some requirement of a yearly audit. My gosh, I'm just a cow trader and we get audited every year just for protection of co-signors because we handle their money.

Mr. A. The only thing that they asked the home health care agency providers to present is a cost report. Once a year you have to do a cost report regarding your cost, but to me that's not a form of auditing. They would not ask for the records. If I had anything to do with Medicare or working with the government, if you're going to bill me $50,000 for the month of October, you are to bill me October 1. I give you the $50,000 within 15 days. That's how long it takes to get a Medicare check. I would require 15 days from the date of getting that check, which would be the end of the month. October 30 you are to have copies of all your medical records and claims in my office for me to assign someone to review the medical record before you bill me again on November 1 for another $50,000. If I find at least 1 percent of fraudulent or have suspicion that you are defrauding us for money, you will not get the second $50,000 so that right there would save the government $550,000 instead of paying me for a whole year and then asking me for a cost report.

Two, you should be able to suspend their license not to allow them to bill anymore until you send someone out to that particular agency to determine if fraud had been done. If there has been more than 10 percent of fraudulent claims that have been submitted for the first act, then at that time you should revoke their license and make them aware that they can get 1, 2, 3 years in prison. So right there you're saving yourself a whole lot of money instead of giving us $5 million and then at the end of 18 months, you want to ask me for some medical records. Ask me for the records within 30

days, and don't pay me for the second 30 days. Then you save your money or what you do is you put me on a pedestal to want to do right—I better do right or I don't get paid.

Senator BURNS. A yearly audit? Do you think a yearly audit—in other words, someone comes in and looks at your books? Do you think that that would have maybe kept you a little closer to doing business the way it should have been done?

Mr. A. It would have helped, but you have to understand that if I got 1 year to clean up my act, and pay nurses to do notes, it is still—you're giving me too much lead way. Every 30 days I've to, like, be on it because you can come in at any time.

Senator BURNS. Well, I would say that that's logical to me even those of us who are bonded.

Let me say what if Medicare reimbursed the patient and the patient paid you?

Mr. A. You may not get it because a lot of patients we were dealing with in South Central, they broker the money in their names. They're going to cash the check——

Senator BURNS. But say the patient—in other words, on that check it's a check that goes to the patient and both you and the patient are named as the payees?

Mr. A. I would agree.

Senator BURNS. Would that help?

Mr. A. Yes, because if we have not provided services, that patient is going to say what is this check for? They're going to send it back to Medicare. So I would agree that that is a form of security that I would probably take.

Senator BURNS. I wouldn't want to suggest that that would be the end result.

Mr. A. No, no, but, you know.

The CHAIRMAN. Well, I'll wait until we come back. [Laughter.]

Senator Burns, I think if you had a situation where an inflated bill was sent to Medicare, Medicare makes the check out to the doctor or the patient and the patient says, "What is this for?" And you say, "Well, it's just for non-services rendered but you get half." That creates another problem.

Mr. A. That would be a problem.

The CHAIRMAN. I don't think that's going to work.

Senator BURNS. That's all the questions I have. I may quit this business and go into his. [Laughter.]

Senator PRYOR. What about bonding? No bonds were required——

Mr. A. No, sir.

Senator BURNS. No bonds required?

Mr. A. No.

The CHAIRMAN. Doctor B, I would like to turn to you if I could. You state that you lost your license in Alabama because of your conviction there, so you had to get a license in California?

Doctor B. I had applied for a California license prior to my actual conviction during the period of indictment. I had a California license——

The CHAIRMAN. So you were indicted but not convicted in Alabama, and you had applied for a license in California? That's how you were able to get it?

Doctor B. Right, during that period.

The CHAIRMAN. Now you indicated when you went to work for Dr. X, you knew at that time that he was not in the business of practicing medicine at that time? He was sort of a front operator using his ID number basically?

Doctor B. Sure, I knew very well at that time, and I let my financial distress cloud my better judgment. After I had returned home without a job, I knew what I was doing and I worked with him under those circumstances.

The CHAIRMAN. So you knew from the beginning that it was a fraudulent operation?

Doctor B. Yes, I knew of it being a fraudulent operation.

The CHAIRMAN. Did other doctors also utilize his ID number, so to speak, and work for him to engage in the billing process?

Doctor B. Well, he had several satellite so-called clinics around town, and he would hire various providers that were either unlicensed, or either a physician associate—or what we call a physician assistant. The physician assistant would be supervised from a distance. He may have never even seen the physician assistant, which would cover the clinic for him.

The CHAIRMAN. You also indicated that most of the patients that you saw were Southeast Asian. Were they Cambodians?

Doctor B. In that particular community, yes.

The CHAIRMAN. Did you speak their language or did they speak English? How did that transaction take place?

Doctor B. Well, I had a translator initially and then I learned to pick up the basic things like how do you feel, what's the problem, just basic diagnostic language. But other than that, I had an interpreter who was a Cambodian interpreter.

The CHAIRMAN. Well, for the benefit of the audience, we've also had some strong evidence that that is another part of the scam where middle men are hired who then go into a refugee community and say, "Let me take you to a doctor and I'll do all the talking, and you can fake that you have mental impairment," by way of example. To qualify for SSI benefits you don't have to say a word. The translator will do all the talking for you. Are you aware of that?

Doctor B. Certainly, usually what happens is that there are the nationals that come over that don't have command of the English language, and they usually have a leader in the community, an unscrupulous leader, that knows about this system and he will take advantage of a group of nationals that don't know anything about the system and just have them—all they know is they signed their names and he would take care of them. He would usually give them a few bucks, which is equivalent to maybe $100 bucks to them in their country so they feel good that all they had to do is sign their name, and whether they were sick or well they could get paid for a visit.

The CHAIRMAN. They wouldn't even have to see you? In other words, you could have a situation where you have a whole immigrant community. Someone would go to them saying, "I've got a way to make you some money. Give me your Medicaid number and such. We will take you to a physician who will examine you and

that physician will provide medications for you even though they're unnecessary," correct?

Doctor B. I don't even think they even knew what was going on. They just had trust that the leader was doing something well to take care of them. They were here in a strange land, and their leader—they entrust their faith in this leader, and all they know is they got money for getting on a bus and a lot of them didn't even know why they were going to certain places. They felt maybe that that was part of the immigration policies to come in and get a physical exam or he could have told them anything. You don't really have—it would be so easy for someone not knowing the system here, and especially not speaking English. So this particular leader, usually he's bilingual, he understands the Medi-Cal—in California we call it Medi-Cal and Medicaid.

One of the things they do there is we have a sticker system where each month the recipient of a Medi-Cal program will receive, say, 10 stickers which permits him to go to the doctor 10 times out of the month. So the patient—if you get the sticker, you don't really need to see the patient. You can get the sticker and turn in that sticker which is kind of like a cashier's check to write up a medical record and write up a claim as to what kind of therapy you gave the patient. So with that one sticker, which they may pay the patient $3, they can make $100 or $200 off each sticker, and each family would have—a family of seven would have 70 stickers. That's one of the things that they will do.

The CHAIRMAN. Before yielding to my colleagues, I want to just pursue a couple of questions with you, Ms. Brambila. It's perplexing to me to understand how you could set up an operation—I guess you call it a loss charge audits operation. You would go to a nursing home and say, "Have I got a deal for you. It's sort of a contingent fee operation. I'll go through your books and look at all of your billing and see whether or not your own billing experts have failed to properly bill Medicare for all its due and owing." What was their reaction about their own billing practices? Would you say they have sloppy billing practices, they've got incompetent people or was it the fact that you were able to produce? You go in the first time and say, "I've found $600,000 or $800,000 that you didn't bill. It's properly yours, and I get a percentage over that and everyone is happy?" I mean, how do nursing homes respond when they find that they haven't been billing properly? Why do they need you? Why not just fire their own billing experts instead of hiring you?

Ms. BRAMBILA. What I can tell you is this—having worked in the industry as long as I have, the nursing home operators predominately are notorious for not paying very well for their own billing people, and many of the people that are doing the billing 2 weeks ago might have been a nurses aide or they might have been a housekeeper. You don't often find in nursing homes—I mean, this is across the country—that the person who is doing the billing had any experience prior to going to work there. They got trained on-the-job, and if they were trained badly because they were trained by somebody who got bad training the same way to begin with who is now the regional person, it's self-perpetuating. A great deal of the fraud that goes on is through stupidity because of the fact that

the billing clerks are doing wrong that they don't even know they're doing wrong because the corporation is literally teaching them fraudulent methods, but that's all they've ever learned.

The CHAIRMAN. So even teaching them fraudulent methods they weren't teaching them well enough?

Ms. BRAMBILA. No—well, they might have been teaching them on some other thing because there are so many different ways to defraud the system——

The CHAIRMAN. I mean, you came along and said, "Hey, I've got a better way to defraud the system. I can get you $800,000 more through my billing scheme as opposed to the one you've concocted."

Ms. BRAMBILA. I think the problem you have is that as the population has changed in the last 25 or 30 years from a predominately private pay population in the nursing homes to where about 75 to 80 percent of them are Medicare and Medicaid patients, the facilities themselves are looking for any way—and they don't care a whole lot about what it is—to get something for nothing.

The CHAIRMAN. Are there any legitimate loss charge audit operations in the country, in your judgment?

Ms. BRAMBILA. I don't believe that there is anybody that I have seen—and I've been in almost every major company there is in the United States as far as geriatric care—that is 100 percent kosher.

The CHAIRMAN. At any time when you were arranging for these reimbursements to come from Medicare to the nursing home, did any nursing home ever raise a question to you?

Ms. BRAMBILA. No.

The CHAIRMAN. What was your percentage of the amounts that you were taking as your——

Ms. BRAMBILA. Fifty percent of what they received, not what was billed but what they actually got paid on.

The CHAIRMAN. You got 50 percent of that?

Ms. BRAMBILA. Right.

The CHAIRMAN. So no questions asked. One thing that was of some confusion to me, how many employees did you have? You had a million dollar payroll, as I understand it.

Ms. BRAMBILA. We did but they were all people doing loss charge audits. Many of them were doing—we had started out as a legitimate company setting up and developing subacute units—mainly attached to acute hospitals—where they were almost like a DRG relief unit so that patients did theoretically go home in a safer, better shape and did not end up in nursing homes. They were licensed as nursing homes, they were funded as nursing homes but they provided a totally different quality of care. We had actually received commendations from some of the health departments in the State of California and other States. So this was a company that had done only good things that went bad. There are so many companies that, like I said, are of very high repute that I can take you right in and in 1 day—I could walk through the facility, take you through the charts and put somebody in Federal prison.

The CHAIRMAN. Mr. Gold, I want to turn to you just briefly. You're the one responsible for Doctor B. having been apprehended and no longer assigned to Club Fed but doing some harder time. He mentioned in his testimony that he had worked previously at

a prescription mill, so-called diet clinics, which were really fronts for drug dealers and amphetamines. Do these clinics still exist?

Mr. GOLD. Mr. Chairman, it's my understanding that they do.

The CHAIRMAN. Could you describe for us how this system works, if you can pull this up so that everybody can see it?

Mr. GOLD. Yes, Mr. Chairman. South Grand Medical Clinic in Orange County, California, is actually very typical of many clinics that we've seen in California and then our correspondence with the National Association of Medicaid Fraud Units suggests that it's very widespread nationally as well. The scam that's depicted on the diagram is the money comes down from Medicaid, and what we see is that money is going—it will appear on your right-hand side—the money goes to South Grand Clinic. South Grand Medical Clinic is submitting claims for having provided services under the name of Dr. X. Well, in reality it's Doctor B, and I say doctor hesitantly because in fact Doctor B, as he testified, had lost his license. So he was the equivalent of you, or me or anybody in this room who is not a physician. He has no business being a physician treating patients, and yet the billing is going under the doctor's name—Dr. X.

The CHAIRMAN. So had he not lost his license at this stage it would not be an illegal scheme?

Mr. GOLD. That is correct. So what you have is claims being submitted under Dr. X's name, but it's not Dr. X nor is it Doctor B. who is actually making the determination of what to bill. You have unlicensed people who have no accountability to the Medicaid program whatsoever who are the owners of this facility. They are also in collusion with the pharmacy, and that would be to the left-hand side. The pharmacy is submitting claims for having provided pharmaceuticals to the patients who were patients of South Grand Medical Clinic—this was Slamad Pharmacy, also in Orange County—and there was an exclusive arrangement between the pharmacy and South Grand.

What we found—our chief investigator, Stan Martin, was there on the premise of the search warrant and they arrested Doctor B. and in comes the owner of the pharmacy, who happens to be a 22-year-old Cambodian, who is not a pharmacist who is there to deal with the owner of the South Grand Medical Clinic, another 22-year-old Cambodian. These are the ostensible owners. Our strong belief, and the evidence suggests, that you have financiers behind the scenes.

The CHAIRMAN. You have basically a 22-year-old Cambodian who owns the South Grand Medical Clinic in business with a 22-year-old Cambodian who owns this pharmacy, right?

Mr. GOLD. Exactly, Mr. Chairman, and what you had is—for this exclusive dealing you had kickbacks being paid by the pharmacy to Rick Kheang, the so-called owner of the South Grand Medical Clinic, by Ahmath Ly. Mr. Ly, the 22-year-old Cambodian who owned the pharmacy, would pay $3 per prescription and that amounted to around $2,000 or $3,000 a month for several hundred prescriptions that would be referred over to the pharmacy.

Well, the pharmacy gets to bill Medicaid, and, as you can see there, $1.2 million billed in a very short period of time. We're talking about these two entities being in existence just about a year, and at $500,000 plus paid to Slamad Pharmacy. A lot of the money

being paid to each of these entities was shut off at the time of the search warrant and the arrests.

So we have that type of kickback, but there is another type which in some ways is a lot more sinister. That's the kickback being paid to the patients, and what you have there is that the patients are—and we're dealing in this instance and many times with an immigrant population. Their introduction to the American health care system is one which corrupts them. Their impression of what they see of America is that you go and you can claim to be sick or the clinic can know you're really not sick, and that's OK because you get paid for coming in. Certainly, you're not paid much because otherwise there wouldn't be any profit for the clinic owner or for the pharmacy, but about $10, which seems to be the going rate with perhaps $3 kicked in by the pharmacy, $7 kicked in by South Grand, and if you have a situation where there are family members, you can have the whole family come on down, socialize with friends there in the clinic for a little while, and they each walk out with, you know, $50 if you've got five members and free pharmaceutical—free to them because Medicaid is paying for it. We've also seen evidence that those pharmaceuticals are shipped back overseas where certain things like antibiotics can net a fairly high premium on the black market overseas.

So you have patients who are being made criminals as well because receiving kickbacks would be illegal.

The CHAIRMAN. Let me just go through it slowly. You have the South Grand Medical Clinic that has been set up presumably by Dr. X, who hires Dr. B, who is no longer a doctor but really is being run by Mr. X, OK, the Cambodian?

Mr. GOLD. Actually the ownership in this instance and the other cases that we have seen actually starts with the—in this case it would be the 22-year-old, and he was interviewed claims that he came up with $100,000 to buy the clinic and then hired the doctor. So it can go the other way as well.

The CHAIRMAN. OK, let's assume he is Mr. X for simplicity's sake right now who is employing Dr. X or Mr. X who does is not practicing, had an ID number, who hires Dr. B. who is no longer a doctor, right?

Mr. GOLD. Yes, sir.

The CHAIRMAN. So you have the clinic. You then have the Cambodian community or any foreign immigrant community that comes into this country, they then go by virtue of a middle man to the clinic. They are examined perhaps or perhaps not examined, but they're brought there. They receive a payment—be it $5 or $10, whatever the amount might be. They then go to a pharmacy with a prescription. They have a prescription and they get the prescription filled or can get it filled—that's one situation where they then get the prescription filled. They may sell that on the black market back in this country or another country, right, and Medicaid is billed? When Medicaid get billed, do they not get billed twice in this respect?

Mr. GOLD. Yes, Mr. Chairman.

The CHAIRMAN. They get billed by the clinic for the services rendered by the doctor examining the patient so Medicaid pays for

that. Second, they have to pay for the drugs that are prescribed so they get paid twice.

Mr. GOLD. That is correct.

The CHAIRMAN. Now do you have a situation where the pharmacy doesn't even deliver any prescription drugs to the individual but rather simply have the prescription—say, they're filling it, they send the bill on to Medicare, or Medi-Cal in this particular case, and they still hold on to the drugs?

Mr. GOLD. Yes, that happens as well. We see a situation often times where the pharmacy doesn't actually have a visit being paid by the patients. The pharmaceuticals are delivered, if at all, to the clinic by the pharmacy, and that's where that allows it to keep this exclusive arrangement and then we do have situations where when we have done some auditing work, we see that—we look at patient charts and we see prescriptions. We see two prescriptions for a patient prescribed, but we look at the pharmacy billing under that same office visit, and we see five prescriptions billed to the Medicaid program. So in that way we're finding this padding of pharmaceuticals that are never delivered.

The CHAIRMAN. Well, is organized crime also involved in this, Mr. Gold?

Mr. GOLD. It's our impression that this is organized crime.

The CHAIRMAN. We've had testimony from Director Freeh who indicates that they've had Operation Rolling Lab in California, as a matter of fact, in which they made some major arrests for similar types of operations. A lab will come into a community, everybody signs up, goes and gets a quick check-up, prescriptions are filled out, they then take those to a pharmacy, which is in fact corrupt, and the system is billed for millions of dollars every year. Organized crime is actively engaged in this operation. I think I've made the comment before, but if Willie Sutton were alive today, he wouldn't have to go to the banks. He would simply have to go to Medicare or Medicaid. That's where the money really is. We're talking about a health care system.

I'm going to conclude—Senator Reid, do you have a question?

Senator REID. Mr. Chairman, I apologize for being late. I had to attend a meeting at the Government Affairs office.

On the information I have here it is not clear who Hardy Gold is. Could you tell me—who are you?

Mr. GOLD. Yes, Senator. I'm with the California State Department of Justice. I'm a Deputy Attorney General and a prosecutor. It was my prosecution of Dr. B. and others in the South Grand scam. We had a pharmacy, we had a clinic owner, we had others who were prosecuted and convicted in that matter, and I was the prosecutor on that case and in other cases that are similar.

Senator REID. How long have you been a U.S. attorney?

Mr. GOLD. Actually, a Deputy Attorney General with the State.

Senator REID. Oh, you're a State prosecutor?

Mr. GOLD. Yes, for a good 5 years in this area.

Senator REID. One of my friends is a prosecutor, a Federal prosecutor, and he deals with Medicare fraud, and he has indicated to me that his work load is overwhelming. He is just overwhelmed with the amount of work. Do you find the same on the State level?

Mr. GOLD. We find that too. We work with investigators, we help them develop their cases and give them advice, and in that way we really both lack resources on the investigative side and on the prosecution side.

Senator REID. Mr. Chairman, I apologize again for not being able to listen to testimony, but I have read the testimony and listened to some of the questions and answers submitted to Ms. Brambila. Is that right?

Ms. BRAMBILA. Yes.

Senator REID. I have to say in reading this—with all due respect—this was not a very clever crime—how did you think you wouldn't get caught? I mean, it seems to me that it was fairly easy to deter.

Ms. BRAMBILA. Because I had been in many, many companies where I had seen the same thing being done and it's still being done right now as we speak, and had there not been this random audit, had there not been this, no one ever would have been caught.

Senator REID. So what this seems to say to me in the little bit of time that I've been here today is that this is an area where we should have more control rather than less.

Ms. BRAMBILA. It's not just area. It's every vendor that deals with the——

Senator REID. Yes, I'm talking about Medicare and Medicaid in general.

Ms. BRAMBILA. Period. I mean, whether it be the lab or it be the medical, or it be the x-ray, whatever it be, everybody is ripping off the system. It's just a question of which way they're doing it and how much they're doing it.

Senator REID. Yes, we—Senator Cohen and I—I think Senator Kohl is here—when we did our hearings on medical equipment——

The CHAIRMAN. DME, durable medical equipment supplies.

Senator REID. That was fraud involved there, also.

Ms. BRAMBILA. That's what this is basically. That's how it's funded under Part B in the nursing home. Most of the stuff that's happening in the nursing homes is actually coming in from outside vendors, and many times the nursing home doesn't even know it's being billed.

Senator REID. So how could this be avoided or prevented?

Ms. BRAMBILA. There are several different ways. One, there needs to be better training of the investigators to know what actually is supposed to happen. I almost had to lead my investigator through the case and explain to him what the real world is like in the nursing home and how these things happened, and I have helped him on other cases since then. The exposure, the knowledge of the actual hands-on goings on of the nursing home is far as the agents is minimal, and they need to be trained.

Senator REID. Mr. Chairman, one of the things we found in the gaming industry to stop cheating is that we used cheaters to help us. We have people come in who have been doing illegal things and they're caught like you, and so then they become employees of the State and they're the best we have. I remember when—I was Chairman of the Nevada Gaming Commission, at one establishment when people from the Gaming Control Board would come in,

they would cheat on purpose just to kind of mess around with them because they didn't know enough about the game of—poker to know that they were cheating. And they were doing it just kind of as a game, and if one of these gaming enforcement agents had had some experience in knowing how the system was cheated rather than what they read in a book, they could have stopped a lot of that. And it seems to me that we have enough people cheating the system that we're going to have to rely on people like you to help us find out how to stop the system from being cheated.

Ms. BRAMBILA. I have offered my services to the government as far back as at the time—with no request of any leniency; I've done my time—for a multitude of reasons, one of which I would like to—I guess one can't atone for one's sins but one would like to at least—I've worked with geriatrics for the last 25 years mainly because I like old people. My mother said to me one time be kind to that old lady you're going to be old someday, and I am rapidly getting there.

I guess the thing I would like to do is I would love to take these agents, put them together in a seminar and take them into what really happens at a nursing home for a week. And I have a feeling that your prosecutions would have a totally different flavor to them and there would be a whole different picture of what you're seeing because nursing home dollars is the faster growing part of Medicare. It used to be this little tiny part of it, and we're not just talking Medicare—we're talking Medicaid. The amount of Medicaid fraud that I see in the nursing homes or people being billed to Medicare and Medicaid and nobody catching it is just—it boggles my mind.

Senator REID. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Reid.

OPENING STATEMENT OF SENATOR HERB KOHL

Senator KOHL. Mr. Chairman, I had meant to ask this question of the second panel and I won't be able to stay for that, but the question I want to ask—and, Mr. Chairman, perhaps you can respond also—is why is it we're not spending enough money to uncover and not eradicate but at least reduce significantly the amount of health care fraud that exists in Medicare and Medicaid. You know, I was in business for most of my life—I was in the retail business—- and we had all kinds of systems and procedures to ensure that the business was operated in an honest way, and we never succeeded 100 percent, but it was up to those who were responsible for running the business to see to it that they had adequate kinds of constraints in place that encouraged people to operate in a manner that was lawful and honest. All the information that I've received and asked for, Mr. Chairman, in this area of Medicaid fraud and abuse is that for every dollar that we invest in procedures and systems to prevent fraud and abuse we get back a multiple of the dollar—$2, $4, $6, $7.

Well, if that's the case, how foolish can we be in not seeing to it that we set up the kinds of systems and procedures and invest the dollars that return multiples of dollars in reducing—and, of course, not eliminating—but reducing health care fraud and abuse so that we at some point in the future won't have to sit here and

be embarrassed for ourselves, and our government and our country that we allow a system as big as Medicare and Medicaid to proceed as fraudulently as apparently it does proceed, which is really a black mark on our country as well as an enormous loss to our taxpayers.

But I guess that's the question I want to pose to you, Mr. Chairman, and to the panel. Isn't that the obvious thing we need to do, which is to intelligently invest in systems and procedures that will reduce the amount of fraud taking place in our system?

Senator REID. Would the Senator yield?

Senator KOHL. Yes.

Senator REID. If I could just make a comment. Mr. Chairman, I see this problem getting worse rather than better because what has happened—you know, we need to cut back the high costs of health care delivery and certainly that's what has happened in the two reconciliation bills that have passed, and so providers are going to be making a lot less money and I think you're going to see more schemes drawn up in the minds of people who feel they're not making enough money from the system.

The CHAIRMAN. Well, let me give you my responses. That's why we're trying to pass the Health Care Anti-Fraud Act, which is now locked up in a conference. It has taken years to develop the law, the statute, that we would like to pass. It's still being opposed by some. There are some in Congress who feel we're being too tough on providers, that we're making a presumption of guilt, that everybody does it, that they're all criminals, that there are no honest providers, and there is strong opposition to the kind of proposals that I have made in the past and that my friends from Wisconsin and Nevada have supported in the past. We have come out with a very strong bill, which is supported by the Justice Department, the FBI, the Administration, virtually all the leadership in the Senate, and yet we find that not everybody shares our views.

One of the basic reasons why this is taking place is you have fewer and fewer people being employed to oversee more and more money, and whenever you have a great deal of money with very little risk of being detected, as Ms. Brambila had indicated, very little chance if you are detected of being prosecuted, and if you are prosecuted, being successfully prosecuted, and if prosecuted successfully, of being convicted, and if being convicted, not sent to Club Fed. So if you take a situation where you have a low risk of detection with high profits, you are going to get a great deal of criminal activity, which is precisely what we have. We have a situation in which we have in the FBI roughly, let's say, 258—what they call—FTE's, full-time equivalents. If you add 228 inspector generals in the HHS, Health and Human Services, you have less than 500 people overseeing the entire Federal health care system looking for fraud. We're talking about each individual being responsible for 8 million claims. That's why it's so easy to defraud the system.

This is not new news for us, Dr. B. and Witness A. We go back to 1981 when Chairman Heinz at that point—Jack Heinz who is no longer with us—held a hearing in which we tried to call upon the expertise of people who have in fact defrauded the system. We called upon an expert witness who was a doctor with impeccable credentials not only as a physician but he had been convicted on

five felony counts, and we called him and said, "Tell us about your experience," and he said essentially what you said Mr. A. and Dr. B. and Tina. He said, "The devil made me do it. It was too easy to resist. I couldn't resist the temptation, and so I succumbed to the temptation. I defrauded the government. I went to prison." He got out of prison and low and behold in 1990 he went from prison to set up an operation in Pennsylvania. He was licensed to practice medicine at a diet clinic—I believe it was in 1990 or 1991—and soon after he was in the diet clinic business, he was right back to doing exactly what he did before they put him in prison. He simply could not resist the temptation.

This past May he was sentenced I believe to 7 years in prison, and I believe he paid a $4 million fine. So, since 1981 we've known about the problem, and we have been unable to persuade our colleagues that we need tougher law enforcement. Even as we speak, and our negotiators between House and Senate are trying to work out some kind of an acceptable agreement, there is pressure coming from the provider community to say, hey, you guys are overstepping the bounds here. This is way too tough on us. You're making criminals out of innocent mistakes, and that's not our intent. Our intent is not to criminalize innocent people. Our intent is to say if you submit documentation, we want you to exercise due diligence. We want you to be able to look at a document you're signing and sending on and be able to say, I can certify with a reasonable degree of certainty that this is a fair billing statement for services rendered.

That is being weakened, as I understand it. There is a notion that we have too many criminals running around the street, violent criminals, we need not focus on this problem. It's a $100 billion a year problem, and so my answer is let's pass the strongest anti-fraud bill that we can pass.

Will that cure the problem? The answer is no. There is no law that we could ever pass that will insulate American society against the genius of the criminal mind. No sooner than we pass these tougher laws, there will be people who will be clever enough to figure out ways in which they can game the system. So it's always going to be catch-up but we can do a great deal to prevent what's taking place today because it's so easy. It is so easy to bilk the system that we are inviting the kind of crime that's taking place. The Director of the FBI says, "We've got organized crime moving into the medical field. They're giving up on drugs because of some risk. Now we've got task force cracking down on drugs with tough sentencing laws. We can move into the medical field with very little chance of detection and even more money." So now we have a wave of organized crime moving into our health care system.

So my answer is that we're partially responsible. We haven't acted responsibly enough by giving the tools to the Justice Department for them to tighten the laws. Right now we're talking about turning all the responsibility back to the States. Let's not have any Federal regulation. We went through this debate last week on the floor of the Senate. We were successful in defeating that with respect to certain parts of the Medicaid legislation.

So I would say that we're all responsible for not taking action sooner, but it's very hard if you've got people opposing legislation.

Some of it is politics. I tried to pass this bill over 2 years ago, but we had an Administration that said, wait a minute. We won't pass this bill. Here's what happened—when the crime bill came up, I offered an amendment to attach the criminal provisions to the crime bill. Guess what happened? It got over to the House and they stripped it out. The House, Ways and Means Committee didn't want it in the crime bill. They said, this is really health care reform so let's wait until we get the President's health care bill and we'll put it in that, and guess what happened? We didn't have a health care bill so another $100 billion ticked off from the Federal Treasury, and that's what has been going on for too long and that's the reason why we have to come up with the strongest possible health care fraud bill that we can because what these gentlemen and this lady are telling us is it's too easy to bilk the system right now of millions, and indeed billions, of dollars every year.

It works out—the numbers I keep repeating are so staggering. It's $275 million a day. It's $11.5 million every hour. We've already lost over $25 million just this morning as we've been sitting here talking through fraud just like these people have talked about.

Senator KOHL. Mr. Chairman, my reaction to listening to what you say, which is eloquent and true, and there is nobody in Congress whether it be the House or the Senate who is a stauncher defender of the proper safeguards and the necessary investment to see to it that we don't have health care fraud to the extent that we do than Senator Cohen. So I'm not here, nor should any of us be here, to point the finger at him. As you can tell from listening to him, he is the leading advocate of seeing to it that we put in the necessary safeguards.

Having said that, Senator Cohen, I think that we all here at the Federal level collectively stand indicted ourselves for having set up a system and then not having set up safeguards to see to it that the system works properly. Who else is responsible for seeing to it that the Federal Medicare and Medicaid system, which we organized, and set up and fund, who is responsible for seeing that it operates effectively? We are and if it doesn't, we have no one to blame but ourselves, and I'm sure you agree.

[The prepared statement of Senator Herb Kohl follows:]

STATEMENT OF SENATOR HERB KOHL

Thank you, Chairman Cohen. I'm glad you called this hearing.

Just last month, six people in Wisconsin were charged with fraudulent billing for transporting Medicaid patients. In one case, more than fifty trips were billed for a nursing home resident who never left the home.

This scheme resulted in false Medicaid billings of more than $300,000 since the operation began in Wisconsin last spring. The criminal investigation is ongoing and even more violations may come to light. Mr. Chairman, for each of these scams discovered, you have to wonder how many go undetected.

Health care fraud is estimated to cost the Nation $100 billion each year. In Medicare and Medicaid fraud alone, the Federal Government loses almost $30 billion every year. Fraud should be the first focus in Medicare and Medicaid reform proposals to save taxpayer spending and preserve these essential programs.

Although we failed in passing a comprehensive health care reform bill last year, health care fraud emerged as a consensus issue that deserves immediate attention in the Senate this year.

I was pleased to join the distinguished Chairman as a cosponsor of his health care fraud legislation and am glad that provisions of Senator Cohen's bill were included in the budget bill.

Unfortunately, the House version of the budget may backtrack on fraud and abuse protections by easing anti-kickback rules, among other provisions. I am concerned that what is seen as restructuring by some involved in the health care industry will be seen by others as an open door policy to bilk the government.

It is my hope that we can touch on potential problems with the House proposal as well as the Senate reform provisions during this hearing.

Thank you, Chairman Cohen, I look forward to the testimony of the panels you have assembled.

The CHAIRMAN. I do agree. I do agree. In fact, if you listened to the debate on the floor last week when we talked about turning over Medicaid as a block grant to the States, the States said no Federal standards; we can handle this ourselves. And, in fact, as a result of the work of this committee, I was successful in working with Senator Pryor to say let's go back to OBRA 87; don't throw that out, and was able to persuade the majority to in fact modify its position because the position of the House is no Federal regulations. The States can handle this themselves.

So, yes, we are responsible for not doing enough to make sure this doesn't happen. It's been going on in virtually every aspect of health care. We can't single out just Medicare and Medicaid. It's CHAMPUS and it's every system in the private sector as well. If we're losing $30 billion or $40 billion a year in Medicare and Medicaid, it's $100 billion nationally with the private system. So the private systems aren't doing a whole lot better in terms of the level of fraudulent activity taking place. The whole system is permeated with fraud, and we have not been doing our job in curbing it.

With that, I'm going to ask you to turn your cameras away for the moment so that the witnesses can leave and ask that you turn the camera in the back of the room away. Our witnesses will proceed out the rear door.

Let me thank all of you for coming forward to testify.

The CHAIRMAN. On our next panel, we have the Attorney General for the State of New York, Dennis Vacco. General Vacco has spent virtually his entire career in law enforcement. For 10 years he was at the Erie County District Attorney's Office where he rose to Chief of the Grand Jury Bureau. He was appointed by President Reagan in 1988 to the U.S. Attorney's Office for the Western District of New York. In 1994 in his first run ever for public office, he was elected to his current position and became the first Attorney General from Western New York since 1925.

We are pleased to have General Vacco with us today to discuss how health care fraud is a major priority in his office, the recent cases and trends in New York as well as the need to have strong anti-fraud provisions, and we look forward to his testimony. He has been very helpful to this committee in the past, and I really appreciate your being here today, General Vacco.

We are also pleased to welcome Sarah Jaggar, the Director of Health Financing and Public Health Issues Section of the General Accounting Office. Ms. Jaggar will provide an overview of the enhancements necessary to combat fraud and abuse, and she is going to be accompanied by Thomas Dowdal, also of the GAO.

General Vacco.

STATEMENT OF HON. DENNIS C. VACCO, NEW YORK STATE ATTORNEY GENERAL, STATE OF NEW YORK, ALBANY, NY

Mr. VACCO. Senator, thank you very much, and I appreciate your kind introductory remarks, but, more importantly, I appreciate the opportunity to be here today to discuss what is obviously a very important topic not only at a Federal level but indeed at the State level as well.

I think that the prior panel has certainly framed the debate today, but there are important issues that I think that we now need to hear about concerning the prosecution efforts of these frauds and abuses.

This year our Nation will spend nearly $1 trillion on health care for approximately 15 percent of our gross national product. With stakes as high as these, it is not surprising that our health care delivery system has proven a ripe ground for fraudulent activity. It is estimated that fraud and abuse accounts for 10 percent of national health care costs, or, as you have already pointed out, roughly $100 billion annually which is lost to fraud.

Fraud in our Medicaid system in New York alone is believed to cost nearly $2 billion annually in New York State. During the past decade in particular we have literally seen a feeding frenzy on the Medicaid program. Wave after wave of multi-million dollar frauds have swept through nursing homes and hospitals, clinics, pharmacies, laboratories, and more recently in the home health care field. Corrupt profiteers are finding every possible loophole to exploit the law.

Some recent cases prosecuted by my office illustrate the continuing plagues spreading through the Medicaid program and provide an important glimpse of some of the latest scams involving Medicaid.

A physician operating a methadone clinic in the Bronx fraudulently charged the State for treating over 25,000 heroine addicts, bilking Medicaid of over $1.5 million over a 5-year period.

Also in the Bronx, a dentist and his wife were accused of running an assembly line operation that processed upwards of 40 patients in a 4-hour day generating nearly $1.2 million in bogus Medicaid billings over a 2-year period. As part of their scheme, the defendants allegedly paid aides to comb men's shelters and breakfast programs for Medicaid recipients, paying them $10 to submit to a brief oral exam.

More recently, we arrested in New York City a retired New York City police detective and two others who were allegedly bilking the system and the taxpayers of the State of over $442,000 by charging Medicaid for phony ambulance trips. Senator Pryor previously mentioned in the course of the prior panel the taxi cab service in Arkansas. Well, this ambulant service over a 4-year period billed over $3 million to Medicaid. We believe at least $442,000 of that billing was fraudulent, and our probe further revealed that the company allegedly made over 9,000 fraudulent claims, and even billed for transporting at least six patients who were deceased at the time they were supposedly ferried to and from medical facilities.

In another case, a psychiatrist pleaded guilty to felony charges involving the theft of over $400,000 from Medicaid. The doctor in

this case submitted to billing for more than 24 hours of psychotherapy treatments in a single day, and even claimed to provide individual therapy to children under 5 years of age, including a crack baby less than 1-year-old.

A current scam that is looting millions of dollars from New York's Medicaid program involves what we call in New York "playing the doctor and drug diversion." These schemes, which are occurring every day in the poor urban neighborhoods, Medicaid patients line up all day to receive prescriptions from phony doctors who provide no medical services. Prescription forms then become the equivalent of a lottery ticket in the drug diversion game, traded for cash or drugs to be resold on the street or collected for shipment overseas.

This fraud is often magnified because these so-called patients are required to give blood samples and have sonograms taken so that other components of the provider system can take part in this illicit enterprise. While the investigation and prosecution of health care fraud has only recently become a top priority at the national level, when I was the United States Attorney in the Western District of New York in the waning days of the Bush Administration, the Department of Justice began to focus us on health care fraud initiatives. But despite the recent focus at the national level, States have been combating health care fraud for the past 20 years.

In 1977 Congress enacted legislation that established the Medicaid fraud control units across the Nation. I'm glad to say that this legislation was patterned after New York's unit, which was established in 1975. The objective of this legislation was to strengthen the capability to detect, prosecute and punish health care fraud.

I would like to point out, however, that despite the escalating loss to the system, that we have not had a commensurate dedication of resources. Currently, in New York State, including the 75 percent Federal share, we spend on the Medicaid Fraud Control Unit in New York State $22 million, which is down from the highest level in 1987 where we employed 392 people compared to the 300 people today. And in that time period expenditures have skyrocketed from $9.6 billion to over $22 billion in the same period. So while we are spending more on the system, we are spending less on detecting the fraud in the system.

While the remarkable success in detecting and prosecuting Medicaid provider fraud is widely recognized, it is perhaps less well-known that the units across the Nation are the only law enforcement agencies in the country specifically charged with investigating patient abuse and neglect. Though it does not appear that patient abuse in our nursing homes is anywhere near the levels we witnessed during the nursing home scandals of the 1970's, our investigations have made it clear that the abuse, neglect, mistreatment and economic exploitation of nursing home residents is still a serious problem.

Let me for a few moments highlight a few of the cases that my office has prosecuted:

A physician was criminally prosecuted for willful neglect and reckless endangerment of a nursing home patient after he mistook a dialysis tube for a feeding tube. Worst, when the mistake was

discovered after 2 days this same doctor chose to do nothing to help the patient for 10 hours.

In other cases, we have found convicted criminals, including violent felons, a rapist and petty thieves, being made responsible for the care of some of the most vulnerable elderly nursing home patients. In several cases my office charged individual nurses' aides with physically abusing patients as old as 96 years. Some of these cases involve aides slapping wheelchair bound patients, striking patients with dirty diapers, using improper restraints or exposing them to emotional abuse like in the case where an aide taunted an 83-year-old bedridden gentleman by accusing him of having sexual relations with his own daughter.

In New York State I have proposed a legislative solution to this problem that couples stronger enforcement, criminal background checks and fingerprinting for prospective nursing home employees with tougher penalties for abuse. In addition to the patient abuse and neglect cases, we are finding significant fraud involving other major provider groups such as laboratories, home health care and medical transportation.

Aggressive marketing techniques not traditionally associated with the health care industry have increased costs by adding marginally necessary or totally unnecessary tests to health care bills. One such example is the recent National Health Laboratories case. In that case physicians were misled into ordering a rare but expensive diagnostic test when they needed only an inexpensive, basic blood chemistry. The corporation eventually settled with the Federal Government for $100 million and with 33 States for $10.4 million.

Billing for useless laboratory tests and cheating both government and private insurers is still occurring. In Maryland, for example, a laboratory and its owner were found guilty of billing government and private insurers for performing more than 8,000 unauthorized and useless diagnostic tests costing taxpayers nearly $150,000.

Already the fastest growing part of the Medicaid funded health care system, State and Federal outlays in the home health industry have ballooned in the past 5 years. In 1994 more than 7.1 million people were expected to receive some form of home care assistance. The current Medicaid Federal share for home health care is $4.1 billion and is expected to balloon to over $18.4 billion by the year 2000. This increase is due to our aging population, shorter hospital stays and an increase in technology.

Since the 1970's technology has advanced to the point of allowing more and more patients to remain in their homes and receive treatment. In this area too my Medicaid Fraud Unit has been very active. The owner and billing clerk of a New York home health care agency were convicted of stealing more than $1 million over 3 years.

In a recent statewide audit of New York's care at home program identified more than $2.4 million in Medicaid overpayments. Among the more rapidly growing segments within the home care industry is the use of home infusion treatments currently estimated to cost $4 billion. The potential for fraud in this rapidly expanding and highly expensive industry is clear. Kickbacks to doc-

tors to authorize medically unnecessary treatment, services or supplies whether or provided or not is cause for concern.

In New York we recently concluded a case that resulted in the largest ever civil fraud settlement in the Nation. Caremark Corporation, a supplier of durable medical goods, was charged with paying kickbacks to doctors to induce referrals. As a result of our investigation, the company agreed to pay $161 million in settlement costs. Virtually every State has seen egregious examples of fraud by non-emergency medical transportation companies. Medicaid will generally pay for patients' transportation to a medical provider when mass transportation is unable, but when the patient because of a debilitating physical or mental condition cannot use other methods of transportation.

Some examples of medical transportation fraud, including billing for an excessive number of miles per trip, billing for recipients who drove themselves, paying kickbacks to recipients who use the medical transportation services, allowing non-eligible people to use another recipient's card in submitting falsified appointment dates for transportation services.

The larger port of entry cities in the United States, including New York City, have recently become the targets of so-called hit-and-run schemes. Four nationals fraudulently obtained a Medicaid provider number and then submit invoices for services never rendered. In larger cities these fake providers often are able to steal millions of Medicaid dollars before their detection, at which time they flee to their homeland.

In one such case in New York the perpetrators went so far as to establish a medical laboratory that offered to pay $10 for a pint of the Medicaid patient's blood. Once the owners of the laboratory obtained the blood and the Medicaid eligibility numbers of the patients, they would submit the bills for extensive and costly blood work, the results of which the patients would never receive.

The laboratory owners were discovered only when numerous patients had given so much blood that they began to show up at local hospitals for emergency care.

Both the Medicaid and Medicare programs are utilizing managed care delivery systems. Proponents of managed care believe that it is the best method of providing low cost, high quality care to a large number of people. Part of the savings for managed care is expected to result from paperwork reduction. The traditional Medicaid provider fraud investigation focuses on over-utilization of services and fraudulent billing. On the other hand, the evil in managed care more likely lies in the under-utilization of services.

Financial considerations will cause some unethical providers to render less care to unhealthy patients. Unlike the typical Medicaid provider fraud, the human costs in terms of reduced access to quality care may indeed be tremendous.

Cooperative efforts between State and Federal authorities have proven very effective in protecting Medicaid and Medicare from health care providers or vendors whose activities involve both programs and cross State lines. The result has been an unprecedented willingness on the part of State and Federal agencies to reach global settlements. Mechanisms are now in place in most States which facilitate the prompt resolution of Federal and State claims. Medic-

aid fraud units of the various States have developed uniform procedures to coordinate joint efforts in resolving Medicaid related claims arising from interstate providers through the National Association of Medicaid Fraud Control Units.

In one of the largest multistate agreements of its kind, 27 State Medicaid fraud control units and the District of Columbia negotiated a final settlement with NME Psychiatric Hospitals, Inc. for $16.3 million. The charges were based on the payment of kickback to doctors so that they could refer to patients to NME hospitals.

Under the current law State Medicaid units are funded 75 percent Federal, 25 percent State government. The Federal match is considered part of the Medicaid program's administrative costs, which are contained in the budget of the Health Care Financing Administration. The funds for the fraud control units are subsequently transferred to HHS or the Office of Inspector General at HHS for distribution.

I believe that restoring the integrity of the program such as Medicaid must be an essential part of any discussion of changes to the existing law and program. State Medicaid fraud enforcement should continue to be a Federal priority in the State's administration of their Medicaid programs. This would maintain the separate and distinct character that has made the units successful in detecting and prosecuting Medicaid fraud.

Federal oversight should continue to be invested in the Office of Inspector General of the Department of Health and Human Services to maintain law enforcement sensitivity on oversight issues. Separation of the MFCU's, the Medicaid fraud control units, from the Medicaid agency was considered a critical component of 95–142, which created the State Medicaid Fraud Control Unit Program. Congress recognized that law enforcement functions can best be accomplished by law enforcement agencies. The responsibility of administering the program necessitates a close association with the provider community.

This is incompatible with and detrimental to the policing function. The MFCU program has many of the currently discussed characteristics of the block grant program. Most significant is the State's ability to adopt individual enforcement approaches. The philosophy of current Federal grant oversight is to require each State to maintain the resources necessary to operate an effective and efficient Medicaid Fraud Control Unit.

I strongly urge, Senator, that this practice continue and be a requirement for any future block grant programs involving Medicaid. The deterrent effect of the MFCU investigations and prosecutions have saved countless millions of Medicaid dollars and will continue to do so. If anything, these units must be enhanced monetarily and legislatively. The history of Medicaid has taught us that decreased vigilance has always led to increased fraud and greater loss.

I am supportive of additional law enforcement tools currently being proposed that would assist States in the prevention, detection and control of health care fraud and abuse. For a number of years the Medicaid fraud control units have been interested in expanding the jurisdiction beyond the Medicaid program, specifically as you are recommending and to other federally funded health care programs such as Medicare.

We are painfully aware corrupt providers will not defraud only Medicaid. This year an unprecedented agreement reached between the National Association of Attorneys General, HHS, the National Association of Medicaid Fraud Control Units and the United States Attorney General to expand the jurisdiction of the units into Medicare and other federally funded programs took place.

I support this agreement, which is reflected in S. 1088, Title 6, the Health Care Fraud and Abuse Prevention Act of 1995, which you have introduced.

In closing, I would like to emphasize, Senator, that the Medicaid fraud control units are viewed as having a national leadership role in detecting and prosecuting fraud and abuse in government funded health care programs. The units have been successful in serving as a deterrent to health care fraud, in identifying program savings, removing incompetent practitioners from the health care system and in preventing physical and financial abuse of patients in health care facilities.

Mr. Chairman, you should be congratulated for your leadership role on a national level. I thank you for the opportunity to be here today, and I would entertain questions that you may have on this subject.

[The prepared statement of Mr. Vacco follows:]

PREPARED STATEMENT OF DENNIS C. VACCO

I am Dennis C. Vacco, New York State Attorney General. I am very pleased to appear before you to discuss the role of the States in investigating and prosecuting health care fraud.

The skyrocketing costs associated with health care delivery and the continued "graying" of our population have resulted in an increased reliance upon government-sponsored programs such as Medicare and Medicaid to provide much needed health insurance to those who would otherwise go without medical care.

The Medicaid program, which was established to provide health care to indigent patients, has seen its enrollment explode. The Health Care Financing Administration is expected to spend more than $170 billion nationwide in fiscal year 1996 to sustain it. When the program started 30 years ago, Medicaid expenditures were $1.5 billion.

State expenditures for Medicaid have doubled in the past 5 years. In some urban areas such as Los Angeles, Baltimore and New York, it is not uncommon for one-forth of the population to rely on the Medicaid program for their basic health needs. Even though Medicaid is generally funded 50 percent by Federal money, several States now spend between 15 percent to 20 percent of their general budget to sustain the program. Medicaid also continues to finance almost half of the total costs for nursing homes, spending 45 percent of the $53 million that was spent on institutionalized care in 1990.

This Nation is expected to spend $1 trillion on health care or 15 percent of our gross national product this year. Given these figures, it is not surprising that our health care delivery system has proven ripe for fraudulent activity.

It is estimated that fraud abuse accounts for 10 percent of health care costs, currently exceeding $800 billion. While there may not be a way to establish a precise figure, we are certainly talking about many hundreds of millions of dollars of fraud and abuse in the Medicaid program alone.

During the past decade, in particular, we have literally seen a feeding frenzy on the Medicaid Program. Wave after wave of multimillion dollar frauds have swept through nursing homes and hospitals, to clinics and pharmacies, durable medical equipment (DME), radiology and labs, and more recently, home health care. Although we do the best we can to put an end to program vulnerabilities, we still have profiteers who search and succeed in finding the next great loophole in the Medicaid system.

Here are a few examples of some recent cases my office has prosecuted that illustrate the continuing plague spreading through the Medicaid Program:

• Dr. Ross Hamilton, a Manhattan physician who operated Genesis Medical, P.C., a methadone treatment center in the Bronx, was sentenced to 2–6 years in prison for stealing more than $1.5 million from 1989–1993 by fraudulently charging the State for over 25,000 methadone treatments never given to Medicaid recipients. In his illicit 2-year billing scheme, Dr. Hamilton not only used the Medicaid numbers of Genesis patients who had not yet begun the methadone program or had died, but brazenly appropriated the names and ID numbers of hospital patients who were neither in his care nor even on methadone.

• Chester Redhead, a dentist, and his wife, Lucia Redhead, were accused of running an assembly-line operation in the Bronx that processes upwards of 40 patients in a 4-hour day and generated nearly $1.2 million in bogus Medicaid billings over a 2-year period. As part of their scheme, they allegedly paid aides to comb men's shelters and breakfast programs for Medicaid recipients who, for $10 in cash, would come to the dental clinic and submit to a brief oral exam. The dentist hired by the Redheads to man the clinic actually resided in a homeless shelter himself, allegedly performed no real dental work, and in fact, had no operating equipment on the premises.

• Recently a retired New York City police detective and two others were arrested for allegedly bilking taxpayers by charging for phony ambulette trips. William Eisenhauer, the retired detective and part owner of Metro Med Ambulette Inc. of East Rockaway and the others were charged with stealing over $442,000 from Medicaid through an elaborate phony billing scheme between January 1989 and December 1994. An extensive probe by the Unit revealed that the Long Island company allegedly made over 9,000 fraudulent Medicaid claims—and even billed Medicaid for transporting at least six patients who were deceased at the time they supposedly had been ferried to and from medical facilities.

• Dr. Teresita E. Earley, a Gramercy Park psychiatrist, pleaded guilty to felony charges involving the theft of over $400,000 from the State Medicaid Program. Dr. Earley who cheated the State out of nearly half of the $850,000 paid her in a 5-year period, often billed for more than 24 hours of psychotherapy treatment in a single day and even claimed to provide individual therapy to children under 5 years of age—including a 'crack' baby less than a year old.

• Following a 17-day jury trial in Westchester County Supreme Court, Dr. Lawrence Orvieto, a White Plains oral surgeon, was convicted of stealing over $200,000 from 1986–1991 by fraudulently overbilling the State for dental services he provided to Medicaid patients. For example: he repeatedly billed for complete or partially impacted tooth extractions (reimbursable at $50.50 per tooth) when only simple extractions (reimbursable at $10.50 per tooth) were performed; billed for soft tissue impaction and surgical root removals (reimbursable at $19.50 per tooth), when simple tooth extractions were actually done, billed for the removal of cysts and tumors (reimbursable at $32.50 per procedure) which were actually done, billed for general anesthesia (reimbursable at $20, plus $10 per 15 minutes of anesthesia time), when in fact nitrous oxide (not reimbursable) was provided.

• Dr. Stanley Wolfson, a Bronx radiologist residing in East Hampton, Long Island, was recently convicted of systematically stealing more than $1 million between 1988–1990 by falsely billing the State for having read and reviewed over 2,700 Medicaid patients' sonograms knowing that the tests were medically unnecessary, often duplications and done solely for the purpose of increasing Medicaid billings—and that the results would not even be furnished to the patients.

• Dr. Emilia Strogov, a podiatrist, was sentenced to 1–3 years in prison for stealing more than $200,000 from 1984–1988 by repeatedly billing the State for high-priced custom foot molds never given to her Medicaid patients.

• Richard Thron, the owner-president of Orthotic Technologies Lab. Inc., Dawn Vollor, its office manager, and Thron's stepdaughter allegedly stole over $250,000 from Medicaid and substantial additional sums from other 3rd-party insurers. The defendants are charged with filing 100's of false reimbursement claims, between April 1, 1988 and August 3, 1994. It is alleged their claims stated that the company had provided patients with various types of expensive orthotics and services such as body jackets (reimbursable at ($1,150—$1,450), shoulder and elbow orthoses (reimbursable at $40 and $775, respectively), and multiple post collars (reimbursable at $525) when, in fact, other cheaper items had been delivered.

• Joseph Githinji Muigai, operator of both the Uptown Medical Clinic and Lari Pharmacy at the same Manhattan location, was recently convicted of stealing over $3.2 million from 1986–1991 by fraudulently billing the State Medicaid Program for medical services never provided and for over 15,000 expensive, medically unnecessary drug prescriptions written by clinic employees who often were not even doctors. At Muigai's 'upstairs-downstairs' pharmacy-clinic on Broadway, physicians and non-physicians alike allegedly prescribed millions of dollars worth of medication without

the slightest pretense of medical treatment. After these multi-item prescriptions—reimbursable by Medicaid at about $42 each—were filled, the recipients usually sold their drugs on the street for a few dollars in cash.

• The most current scam that is looting many millions of dollars from the New York State Medicaid program involves what we call "playing doctor" and drug diversion. The playing doctor scheme, which is occurring every day in our poorer urban ghettos, involves Medicaid "patients" lining up during all hours of the day to receive prescriptions, which they usually pay for, from "doctors" who provide no medical services. This fraud is magnified because these so-called patients are then required to give blood samples and have sonograms taken so that other components of this illicit enterprise can also steal. The prescriptions then become the ticket needed to play the drug diversion game. They are filled at illegitimate pharmacies in New York City where the "recipients" either get cash or take the drugs to resell on the street. These drugs are then sold to other pharmacies or collected by diverters for shipment overseas. My office has been arresting individuals with pockets full of forged or illicit prescriptions of this kind. I have a major project devoted to this problem.

STATE MEDICAID FRAUD CONTROL UNITS

While the investigation and prosecution of health care fraud has only recently become a top national law enforcement priority, the States have been combating health care fraud for the past 20 years and are viewed as leaders in the detection and prosecution of fraud in the health care industry. Medicaid, established by Congress in 1965 is of course, the primary government health care program for approximately 34 million of America's poorest and oldest citizens. For the first decade after Medicaid was created, the system operated with few controls against fraud. Inadequate safeguards combined with multi-billion dollar expenditure levels made a substantial amount of fraud inevitable. The result was an unprecedented theft of government dollars as local prosecutors struggled with the difficult task of prosecuting these highly sophisticated crimes. Congress came to recognize an urgent need to address this loss after much media attention and Congressional hearings highlighted the theft of taxpayer dollars and the harm suffered by Medicaid patients who were deprived of basic medical care. The result was legislation to establish specialized state-based strike forces to police the Medicaid program.

In 1977, Congress enacted legislation, the Medicare-Medicaid Anti-Fraud and Abuse Amendments, P.L. 95–142 which established the State Medicaid Fraud Control Unit Program, patterned after the New York Unit that was established in 1975. The objective of this legislation was to strengthen the capability to detect, prosecute and punish health care fraud. In addition to investigating and prosecuting providers who defraud the Medicaid program, the mandate to Medicaid Fraud Control Units (MFCU's) specifically includes the authority to prosecute the abuse or neglect of patients in all residential health care facilities which are Medicaid providers. The Units are staffed by professional teams of attorneys, investigators and auditors specifically trained in the complex litigation aspects of health care fraud. The enabling Federal legislation emphasizes the necessity of having an integrated multi-disciplinary team in one office in order to successfully prosecute these complex financial crimes. The Units are required to be separate and distinct from the State Medicaid programs and are usually located in the State attorney general's office. Some Units, however, are located in other State agencies with law enforcement responsibilities such as the State police or the State Bureau of Investigation. The recently enacted Omnibus Reconciliation Act requires all States to have a Medicaid Fraud Control Unit by this year, unless a State can demonstrate to the Secretary of the Department of Health and Human Services (HHS) that it has a minimum amount of Medicaid fraud and that residents of health care facilities that receive Medicaid funding will be protected from abuse and/or neglect.

Since the inception of this pioneering program, 45 federally certified State units have successfully prosecuted over 7,000 corrupt medical providers and vendors and elder abusers. These convictions would not have occurred without this vital piece of legislation. The Units police 92 percent of the nation's Medicaid expenditures with a combined staff of approximately 1,150 and a total Federal budget of $69 million. This amount represents a small fraction of the total Medicaid budget that the Units are responsible for policing. Last fall, South Carolina became the 43rd unit federally certified. Georgia and Wyoming were certified in January of this year and became the 44th and 45th MFCU's. Unit size varies state-by-state and is dictated to some extent by the size of the State's Medicaid program.

In addition to the criminal consequences of MFCU cases such as repayment of restitution, overpayments, State exclusions, incarceration, and often the loss of certifi-

cations, the ability to conduct business and professional licenses, the criminal convictions of the Units become the basis for further Federal actions. The Federal actions that are reported to you by the Office of Inspector General (OIG) of the Department of Health and Human Services (HHS) include the underlying State convictions, judgments, forfeitures, civil settlements, Federal program exclusions, and civil monetary penalties. In fact, the majority of health care fraud convictions, penalties, and exclusions reported to you are based upon MFCU convictions. The MFCU's are the most efficient and effective law enforcement agencies in the battle against health care fraud and patient abuse.

PATIENT ABUSE AND NEGLECT

While this remarkable success in detecting and prosecuting Medicaid provider fraud is widely recognized, it is perhaps less well known that the Units are the only law enforcement agencies in the country specifically charged with investigating patient abuse and neglect.

Patient abuse can be classified into several categories: providing inadequate medical or custodial care or creating other health care risks may constitute patient neglect; physical abuse, includes acts of violence such as slapping, kicking, hitting or punching a patient and sexual abuse; financial abuse includes the misappropriation of patients' personal funds such as comingling patient and facility funds or using funds to pay for facility operations.

Scores of investigations and years of cumulative experience have made it clear that the abuse, neglect, mistreatment, and economic exploitation of nursing home residents is a problem of far greater magnitude than previously thought. The National Association of Medicaid Fraud Control Units, in collaboration with the National Association of Attorneys General (NAAG), has therefore promulgated a model patient abuse statute already adopted in several States. The model statute not only provides the necessary prosecutorial tools and enhanced penal sanctions for combating this type of shocking misconduct, but it also serves as a powerful deterrent to potential patient abusers.

Let me highlight two examples of the Units' work in this area:

• A New York physician was criminally prosecuted by my office for willful neglect and reckless endangerment of a nursing home patient in his care. He mistook a peritoneal dialysis catheter in the patient's abdomen for a feeding tube, and ordered that she be fed through the catheter. When this error was discovered 2 days later, he made a conscious decision to do nothing to help the patient despite expert advice that the patient required hospitalization for treatment. Finally, 10 hours later, the physician agreed to transfer the patient to the nearby hospital for care.

• In Arizona, a residential care home owner was sentenced to serve 21 years, the longest sentence for elder abuse in the State's history, for neglecting and abusing his aged patients. To induce families to place their relatives in his facility, the defendant had lied to them about his licensure status.

PROVIDER FRAUD SCHEMES

In the past decade, we have seen a rapid increase both in the number of fraudulent schemes and the degree of sophistication with which they are committed. Although the typical fraud schemes such as billing for services never rendered, double billing, misrepresenting the nature of services provided, providing unnecessary services, false cost reports and kickbacks still regularly occur, new and often innovative methods of thievery have consistently occurred and are even just beginning to appear.

Medicaid fraud cases run the gamut from a solo practitioner who submits claims for services never rendered to large institutions which exaggerate the level of care provided to their patients and then alters patient records in order to conceal that lack of care. MFCU's have prosecuted psychiatrists who have demanded sexual favors from their patients in exchange for prescription drugs, nursing home owners who steal money from residents, and even funeral directors who bill the estates of Medicaid patients for funerals they did not perform.

The following are typical schemes corrupt providers may use to defraud the Medicaid program.

1. Billing for services not rendered.—A provider bills for services not rendered, x-rays not taken; a nursing home or hospital continues to bill for services for a patient who is no longer at the facility either due to death or transfer; psychiatrists bill for SSI qualifying exams which do not occur.

2. Double-billing.—A provider bills both the Medicaid program and a private insurance company (or the recipient) for treatment or two providers request payment on the same recipient for the same procedure on the same date,

3. Substitution of generic drugs.—A pharmacy bills the Medicaid program for a brand name prescription drug, when a low cost generic substitute was supplied to the recipient at a substantially lower cost to the pharmacy.

4. Unnecessary services.—A physician performs numerous tests which are medically unnecessary and result in great expense to the insurer.

5. Upcoding.—A physician bills for more expensive procedures than were performed, such as a comprehensive procedure when only a limited one was administered; a psychiatrist bills for individual therapy when group therapy was given.

6. Kickbacks.—A nursing home owner requires another provider, such as a laboratory, ambulance company or pharmacy, to pay the owner a certain portion of the money the second provider receives from rendering services to patients in a nursing home.

7. False Cost Reports.—A nursing home owner or operator includes inappropriate expenses for Medicaid reimbursement.

NEW SCHEMES AND TRENDS

Over the past few years, these so-called "typical" schemes have given way to more innovative ones. Recently, the Units have identified serious fraud problems in several industries including laboratories, home health care, medical transportation, medical supplies, pharmacies, and imaging centers. Additionally, the incidence of illegal drug diversion has risen sharply over the years, carrying with it a dramatic financial impact on the Medicaid program. This is currently a major problem in New York City.

More and more States are enrolling their Medicaid population into managed care plans. While proponents of the managed care system believe that it is the best method for providing low cost high quality health care to more people, the experience of the fraud units reveal that no health care plan is immune from fraud and indeed fraud does occur in managed care plans.

Recent global settlements of cases involving multiple State and Federal entities have encouraged cooperative Federal/State efforts to protect the Medicare/Medicaid programs from health care providers or vendors whose activities know no borders.

BUSINESS MANAGEMENT COMPANIES

A significant trend is the merger, acquisition, consolidation, affiliation, and joint venture of health care corporations as a cost-saving business practice. The result is that the business judgments are overriding medical practices. This can be seen in the laboratory cases, such as NHL and National Medical Enterprises, Inc. (NME). In addition, we are beginning to see this in the form of self-referrals. Couple this with greed, unregulated businesses, and big government dollars, and it equals disaster.

LABORATORIES

Aggressive marketing techniques, not traditionally associated with the health care industry, have increased costs by adding marginally necessary or totally unnecessary tests to health care bills. One such example is the recent National Health Laboratories, Inc. (NHL) case where physicians were misled into ordering a rare, but expensive, diagnostic test when they needed only an inexpensive and basic blood chemistry. Investigators found that NHL induced doctors to order laboratory tests which were medically unnecessary by assuring that the additional tests would be free or of minimal cost. In fact, NHL was billing government insurers for these tests without the referring physician's knowledge. As a result of the scheme, the president and chief operating officer of NHL was sentenced to jail; and the corporation, after pleading guilty, settled with the Federal Government for $100 million and 33 State MFCU's for $10.4 million.

Billing for useless laboratory tests and cheating both government and private insurers is still occurring. In Maryland, a laboratory and its owner were found guilty of numerous counts of fraud and theft. The defendants were charged with billing government and private insurers for performing more than 8,000 unauthorized and useless diagnostic tests totaling nearly $150,000. The owner was also convicted of representing a laboratory which was in violation of the States quality assurance cases. He was sentenced to 5 years in jail and ordered to pay $161,000 to Medicaid, Medicare and several commercial health insurance companies.

The Illinois MFCU has charged several defendants with allegedly establishing a phony lab and billing Medicaid and private insurance companies for lab tests that were never preformed. During a search of one of the defendant's home, tubes of what appeared to be human blood were found in the garbage can. Before the scheme

was exposed, over $300,000 in payments from Medicaid and insurance companies passed through the corporate bank account.

Laboratories that provide drug testing for substance abuse programs have also been the subject of MFCU investigations. The Massachusetts MFCU indicted a drug testing laboratory and its president for allegedly overcharging Medicaid for tests it performed and then used in a series of fraudulent billing schemes to increase their billings even more. In Pennsylvania, a laboratory agreed to pay $750,000 to settle allegations that it overcharged the State for testing done for drug and alcohol facilities and hospitals in the Pittsburgh area.

HOME HEALTH CARE

Already the fastest growing part of the Medicaid-funded health care system, State and Federal outlays in the home health industry have ballooned in the last 5 years. In 1994, more than 7.1 million people were expected to receive some form of home care. The current Medicaid Federal share for home health care is $4.1 billion and is expected to reach $18.4 billion by the year 2000. This increase is due to an aging population, shorter hospital stays and an increase in technology. Since the 1970's, technology has advanced to the point of allowing more and more patients to remain in their homes and receive treatment. The profile of a typical home health care recipient is one who is elderly, disabled, has AIDS, heart disease, diabetes or has been discharged from the hospital and needs more care.

Not only are home health care agencies charged with grossly inflating the number of hours their employees worked, but, more importantly, in some cases with recklessly sending untrained, unqualified, and unlicensed aides into private homes of thousands of critically ill and care-dependent patients. It is an industry that contains all of the components for disaster. It is unregulated in the traditional medical sense, multiple agencies are involved with large amounts of government money and it is attractive to the consumer.

Let me highlight a few examples of the Units' work in this area:

- Five people in California were paid for up to a year for caring for relatives who had died. These caretakers were also recipients of other government programs. Both they and the program paying them failed to report the offsetting income.
- A certified nurse's aide in Maine was sentenced to 3 years in jail, with all but 30 days suspended, and to 4 years probation for adding her name to a number of credit cards that belonged to the patient and making purchases on those cards totaling $7,196.13.
- My office convicted the owner and billing clerk of a New York home health care agency for stealing more than $1.1 million dollars, during a 3-year period. The defendants billed the State for professional nursing services rendered to thousands of homebound Medicaid patients by unqualified workers.
- A recent statewide audit of New York's Care At Home Program, also known as the Katie Beckett Waiver Program, identified more than $2.4 million in Medicaid overpayments. The audit revealed that during a 4-year period, Medicaid was not only charged for services more properly payable to patients' private insurance policies, but also billed via special codes that bypassed the routine prior approval process and resulted in substantial overpayments.
- In one county in California, there are no less than 74 home health service agencies, many of which line up, literally, at board and care homes offering competitive incentives for home health care business within the facility. These agencies are potentially turning board and care homes into health facilities that are virtually unlicensed, non-certified, non-regulated and practically invisible.

Among the more rapidly growing segments within the home health care industry is home infusion treatments, currently estimated to cost $4 billion. Home infusion treatments include more than the actual medication. In addition to drugs and nutritional formulas, treatments include supplies such as tubing, syringes, alcohol swabs, bottles, gloves and needles, and expensive equipment such as pumps, nebulizers, glucose monitors and blood pressure kits that are regularly utilized by the victims of these serious illnesses, all of which are billed on a regular basis. A large amount of the funds, too, are spent in the area of home care services. Regular visits, frequently more than once a day, by a R.N., nurse practitioner, home health aide, a physician's assistant or even a physician, are required and reimbursed. Further, regular visits to a physician for certification of continued need and dosage adjustment are necessary. Again, a classic recipe for fraud with fragmented billings: drugs are billed by the pharmacies; the supplies used to assist in administering the drugs are billed by the DME provider; professional services are billed by the home health service company or individual providers; and personal services may be billed to var-

ious agencies. In California, Medicaid block grants are given to counties who pay in-home services out of various funding sources.

The potential for fraud in this rapidly expanding and highly expensive industry is clear. Kickbacks to doctors to authorize medically unnecessary treatment, services or supplies, whether provided or not, is cause for MFCU concern. A recent national investigation involving Caremark, resulted in a $161 million settlement because of that provider's involvement in fraud and kickbacks which were paid to induce referrals. New York State alone collected more than $15 million with my Office playing a leading role in that settlement.

Several multi-billion dollar home health care corporations are currently the subject of both Federal and State investigations.

MEDICAL TRANSPORTATION

Virtually every State MFCU has found egregious examples of fraud by non-emergency medical transportation companies. Medicaid will generally pay for a patients transportation to a medical provider either when mass transit is unavailable in the recipient's area or when the patient, because of a debilitating physical or mental condition cannot use this method of transportation. Examples of medical transportation fraud include, billing for an excessive number of miles per trip for services actually provided, billing for recipients who drove themselves, paying kickbacks to recipients who used the medical transportation services, allowing non-eligible persons to use another recipients card, submitting falsified appointment dates for round-trip transportation services to a provider's offices, charging billing for emergency transportation for non-emergency situations, billing for fictitious services not covered by the Medicaid program or for transportation that was not provided, and creation of phony certificates of need ostensibly by doctors, and kickbacks to doctors for improperly certifying the need.

Transportation fraud is also committed by ambulance providers as well. In Pennsylvania claims were filed to the State requesting reimbursement for ambulance trips that were not medically necessary. Many of these trips were to doctor's offices, which are not reimbursable under Medicaid regulations, but were misrepresented as being trips to hospitals.

A Minnesota company that provided ambulance and medical transportation reached a $3 million dollar settlement with State and Federal authorities for falsely billing the Medicaid and Medicare programs. The company billed these programs for basic life support ambulance transportation claiming that the rides were medically necessary, when a lesser form of transportation would have been adequate.

The general transportation program in Maryland virtually collapsed under the weight of fraud and abuse. In 1988, the program cost taxpayers $4.5 million per year. Fraud, abuse and aggressive marketing caused the demand for program services to increase four-fold in 4 years, for a cost of $16.2 million in 1992, at which time this benefit was severely restricted.

In California, a State that pays for almost no transportation services, nearly $1 million was recovered from bank accounts hours before the money was to be transferred out of the country. The defendant's had already fled. They had used a combination of phony certificates of need, lying about the mileage and kickbacks to board and care operators for access to Medi-Cal patients.

DRUG DIVERSION

In the early 1980's the diversion of legal drugs for illegal purposes in the Medicaid program frequently involved pharmacists filling prescriptions with generic or other cheaper substitutes for the more expensive, brand name drugs that were being prescribed by physicians or submitting false Medicaid reimbursement claims for higher-priced, brand name medicine. Since then, drug abusers have turned to prescription drugs as their drug of choice and this demand has generated a supply of dishonest health care providers who both abuse their prescribing privileges and incur greater costs to prescription plans, such as Medicaid. In large urban centers, it is not uncommon to find a so-called "pill mill" which has as its primary purpose the issuance of prescriptions of controlled and non-controlled drugs in exchange for cash. These drugs may then by resold "on the street" or sent abroad for black and gray markets for several times their cost. In some instances, we have found that the street addicts resold the prescription drugs to other pharmacies as at a fraction of their original cost and at some risk to the unsuspecting customer of the second pharmacy.

In a typical scenario, a "patient" will visit an unscrupulous doctor and buy, for instance, a prescription for 90 valium at about $1 per pill. After having it filled at an accommodating pharmacy, the patient will resell the pills to individuals at $5 a pop and thereby net a profit of $360. Not factored into this economic equation,

however, is that each participant in the scheme is sustaining the continued addition of countless individuals.

The drug diversion problem is most commonly seen in the following schemes:

1. A Medicaid recipient goes to a doctor's office and pays cash for a controlled drug prescription, which is then filled by a pharmacy. The doctor does not bill the Medicaid Program, the pharmacy does;

2. A "middle man", who is a non-recipient, goes to a doctor and gives him cash for a number of prescriptions for controlled substances with no names or addresses on any of the prescription forms. The middle man then "rents" Medicaid cards from recipients, inks in the blanks on the forms, and goes to a pharmacy to have the prescriptions filled. The pharmacy bills Medicaid;

3. A Medicaid recipient goes to a doctor for a legitimate medical reason and the doctor gives the recipient a legitimate prescription. The recipient is approached outside the doctor's office with an offer to buy the prescription. The recipient often sells the prescription. A business arrangement is then established.

Medicaid prescriptions alone cost the government $5.5 billion in 1991, a cost that is expected to nearly double by 1996 to $10 billion. These costs are not confined to the actual reimbursement for the drugs dispensed, but rather include much greater costs which society must absorb from the continuation of the addiction cycle and its enduring impact on the health of the individual. According to a study released on July 15, 1993 by the Columbia University Center on Addiction and Drug Abuse, $4.2 billion of the $21.6 billion paid by Medicaid for hospital care in 1991 war for care attributable to substance abuse. If one applies that same ratio, just under 20 percent, to all U.S. health case expenditures, this Nation is spending nearly $200 billion a year on care attributable to substance abuse.

"HIT AND RUN"

The larger point-of-entry cities of the United States have noted so-called "hit and run" schemes in which foreign nationals fraudulently obtain a Medicaid provider number and then submit invoices for services not rendered. In larger cities, these fake providers often are able to obtain millions of Medicaid dollars before their detection, at which time they flee to their homeland. In one such case in New York, the perpetrators went so far as to establish a medical laboratory and then offered to buy the blood of Medicaid patients for $10 a pint. Once the owners of the laboratory obtained the blood and the Medicaid eligibility numbers of the patients, they would submit astronomical bills to Medicaid, representing that they had performed an extensive and costly blood work-up, the results of which the patients would not receive. The laboratory owners were discovered only when numerous "patients" began appearing at hospital emergency rooms after selling excess amounts of blood and rendering themselves gravely ill.

FRAUD IN MANAGED CARE

Both the Medicaid and Medicare Programs are utilizing managed care delivery systems. In some States, managed care has been in existence since the early 1980's. Currently, more and more States are requiring greater numbers of their Medicaid population to participate in their managed care programs.

Proponents of the managed care system believe that it is the best method for providing low cost, high quality health care to more people. Managed care is supposed to save money not only in the delivery of services but by reducing the amount of paperwork. While many observers point out that the very nature of managed care prevents fraud, the experience of the fraud units, the Arizona Unit in particular, the Medicare Program and the private insurance industry, reveal that no health care plan is immune from fraud and indeed fraud does occur in managed care plans. Rather, fraud simply takes different forms, in response to the way the program is structured.

While the traditional Medicaid provider fraud investigation focuses on *over* utilization of services and fraudulent billing, the evil of the managed care investigation more likely lies in the *under* utilization of services. Financial considerations will cause some unethical providers to render less care to, or disenroll, the unhealthy patient. Unlike the typical Medicaid provider fraud case, the human cost in terms of reduced access to quality care may be tremendous.

The MFCU's have documented certain types of criminal activity in managed care plans: fraudulent subcontracts; fraudulent related party transactions; excessive salaries and fees to the entrepreneurs involved; bribery; tax evasion; kickbacks; rebates and other illegal economic arrangements; and fraud in the administration of the program. Quality of care problems such as the under utilization of necessary services, falsification or misrepresentation of professional credentials, and the use of un-

licensed providers may occur more frequently in managed care programs than in the traditional fee-for-service payment program. Further, instead of billing numerous unnecessary procedures for a few existing clients, physicians may legally increase their income by agreeing to provide care for hundreds or even thousands of clients for monthly capitation fees. The patients become a captive audience, and the physician has less incentive to find sufficient time to provide good care for his patients.

One Maryland case illustrates one kind of fraud and patient neglect that will be a problem faced by managed health care programs in future years. The Maryland Medicaid program has initiated a limited managed care approach which pays physicians a minimal monthly fee for each patient for whom they assume primary responsibility. The Maryland MFCU recently prosecuted a physician who "treated" between 90–100 patients a day, recording for each patient the identical blood pressure and pulse rate, and using a rubber stamp to diagnose the same ailment for most. The amount of his Medicaid payment his rendering a "comprehensive' medical examination for each patient. The sad truth was that his patients received no medical care and in several cases, suffered from conditions that worsened due to his neglect. When questioned by MFCU staff, he was unable to provide the name of a single patient for whom he allegedly provided care. The physician was convicted of felony Medicaid Fraud.

In California, the State enrolled 1.1 million Medi-Cal beneficiaries into managed care in 1993 and expects to have 2.5 million beneficiaries, 50 percent of the Medi-Cal population, enrolled by early 1996. Bids for contracts with health care service plans, commonly called HMO's are being reviewed at this time.

In California's managed care system, the single State Medicaid agency contracts for some or all of its Medicaid covered services and supplies. The contractor is most often a coordinating business entity, not an actual provider. The services are rendered by employees of the contractors or by subcontractors. The victim of fraud may be the program, the contractor, the subcontractor or the individual provider. The perpetrator of fraud may be an individual within the single State agency, the contractor, an employee or agent of the contractor or subcontractor, or individual provider, or even a related entity that controls the service provider. An example of this is found in the Arizona experience.

The Arizona Health Care Cost Containment System (AHCCS), a statewide prepaid capitated program, began on October 1, 1982, and was the first in the country to offer its citizens a managed care program. The AHCCCS Fraud Unit was established 2 years later. That Unit has extensive experience in investigating fraud in managed care.

In one Arizona case, three former officials of one of the largest health care providers under the AHCCS program were indicted on charges of fraudulent schemes, conspiracy, theft and illegally conducting an enterprise, Health Care Providers of Arizona (HCPA). The three were charged with conspiring to defraud HCPA and AHCCCS by diverting funds lawfully belonging to HCAP to themselves and their businesses. The investigation revealed that the monies were taken out of HCPA in various fraud schemes and thefts in the guise of capitalization, management fees, medical directors fees, bonuses, medical equipment and excessive rental charge. Two of these individuals, a licensed doctor of osteopathy and a medical doctor, both pleaded guilty to one count of fraudulent schemes, and two counts of facilitation of theft. Both were sentenced to 3 years probation and ordered to pay a $14,000 fine, $50,000 in restitution and $50,000 in costs of prosecution. A registered nurse implicated in the scheme pleaded guilty to two counts of facilitation of theft, and was sentenced to 3 years probation, and ordered to pay a $5,400 fine, $5,000 in court costs, and $4,556 in restitution.

As the experience of the State MFCU's demonstrates, fraud does occur in managed care plans. As health care delivery systems become bigger and bigger business, not only will unscrupulous providers find new and innovative ways to criminally profit at the expense of patients and health care payers but so will enterprising businessmen and women.

MULTI-STATE/FEDERAL COOPERATIVE EFFORTS

Cooperative efforts between State and Federal authorities have proven very effective in protecting Medicaid and Medicare from health care providers or vendors whose activities involve both programs and cross State lines. Joint Federal and State task forces have been established in States throughout the Nation, and agents, increasingly are working together to detect fraud against government insurers. One side effect of these efforts has been the recognition by seasoned defense attorneys that all parties must be at the table when any case resolution is discussed. A settlement reached with a State Medicaid Fraud Control Unit in which

all Medicaid claims are resolved, for example, does not necessarily resolve those in other States or any outstanding Medicare claims or their attendant sanctions. The result has been an unprecedented willingness on the part of State and Federal authorities to reach "global" settlements in which all outstanding claims by government insurers can be resolved, and in which all administrative sanctions can be addressed. Mechanisms are now in place in most States which facilitate the prompt resolution of Federal and State claims, and the MFCU's themselves have developed uniform procedures to coordinate joint efforts in resolving Medicaid-related claims arising from interstate providers through the National Association of Medicaid Fraud Control Units.

For example, last year, the Department of Justice announced that a settlement was reached with NME Psychiatric Hospitals, Inc., which manages more than 60 psychiatric hospitals and substance abuse centers nationwide. NME Psychiatric Hospitals, Inc. is a wholly owned subsidiary of National Medical Enterprises, Inc. (NME), which is headquartered in Santa Monica, California.

In one of the largest multi-state agreements of its kind, 27 State Medicaid Fraud Control Units and the District of Columbia negotiated a final settlement with NME for $16.3 million. The charges were based on NME Psychiatric Hospitals' payment of kickbacks to doctors, referral services, and other persons so that they could refer patients to NME hospitals. The patients were insured under such government health programs as Medicare, Medicaid, and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) and the Federal Employees Health Benefit Program.

NATIONAL ASSOCIATION OF MEDICAID FRAUD CONTROL UNITS

The National Association of Medicaid Fraud Control Units (NAMFCU) was established in 1978 to provide a forum for the nationwide sharing of information concerning the problems of Medicaid fraud control, to foster interstate cooperation on law enforcement and Federal issues affecting the MFCU's, to improve the quality of Medicaid fraud investigations and prosecutions by conducting training programs and providing technical assistance for Association members, and to provide the public with information about the MFCU program. All forty-five MFCU's comprise the Association.

The Association employs a Medicaid Fraud Counsel, located at the National Association of Attorneys General in Washington, D.C. The Association coordinates and disseminates information to the various Units, maintains a library of resource materials, and provides informal advice and assistance to its member Units and to those States considering establishing a Unit. NAMFCU conducts several training conferences each year and is called upon regularly to supply speakers for numerous health care fraud seminars. It has also co-sponsored training programs with the F.B.I. and the American Bar Association and conducts a specialized academy at the Federal Law Enforcement Training Center.

The Medicaid Fraud Report, published ten times a year is the Association's newsletter. The newsletter contains information concerning prosecutions by various States, reports of legal decisions affecting fraud control prosecution, and analyses of legislation affecting the Medicaid program and the Units. NAMFCU also serves as a clearinghouse for State/Federal cooperative efforts and provides a responsive voice to Congressional inquiries.

MEDICAID FRAUD CONTROL UNIT FUNDING

Under current legislation, Units are funded with 75 percent Federal funds and 25 percent State matching funds on a yearly grant basis except for the first 3 years of a Unit's operation when a Unit receives 90 percent Federal funding. 90 percent Federal funding provides an incentive for establishing a fraud control unit and is also intended to provide a new Unit sufficient time to become fully operational. The Federal match is part of the Medicaid program's administrative costs, which are contained in the budget of the Health Care Financing Administration (HCFA). The funds for the fraud control units are subsequently transferred to the HHS Office of Inspector General (OIG) for distribution to the States. OIG has administrative oversight responsibility for this grant program and certifies and re-certifies the Units to insure that they comply with Federal regulations.

I believe that maintaining program integrity factors are essential if any changes occur in the structure of the Medicaid program. State Medicaid fraud enforcement should continue to be a Federal priority in the States' administration of their Medicaid program. Funding for the State Medicaid Fraud Control Units should continue to go to their sponsoring agencies and should not be included as part of a larger Medicaid grant that is distributed to the States.

This would maintain the separate and distinct character that has made the Units successful in detecting and prosecuting Medicaid fraud. Federal oversight should continue to be vested with the Office of Inspector General of the Department of Health and Human Services to maintain law enforcement sensitivity on oversight issues.

Separation of MFCU's from the Medicaid agency was considered a critical component of P.L. 95–142, which created the State Medicaid Fraud Control Unit program. Congress recognized that law enforcement functions can best be accomplished by law enforcement agencies. Further, in analyzing the reasons for the Medicaid agency's failure to adequately police the program, Congress recognized that there were inherent obstacles. For example, the responsibility of administering the program necessitates a close association with the provider community. This is incompatible with and detrimental to the policing function.

The MFCU program has many of the currently discussed characteristics of a block grant program. Most significant is the States' ability to adopt individual enforcement approaches. The philosophy of current Federal grant oversight is to require each State to maintain the resources necessary to operate an effective and efficient Medicaid Fraud Control Unit. I strongly urge that this practice continue and be a requirement for any future block grant programs involving Medicaid.

In addition, I believe that it should be mandated that funding remain in place to support the Medicaid Fraud Control Units. These Units have a proven record of law enforcement oversight of the Medicaid Program. The deterrent effect of their investigations and prosecutions have saved countless millions of Medicaid dollars and will continue to do so. If anything, the Units must be enhanced monetarily and legislatively rather than threatened. The history of Medicaid has taught us that decreased vigilance has always led to increased fraud and greater loss.

Finally, I am supportive of the additional law enforcement tools, currently being proposed, that would assist States in the prevention, detection and control of health care fraud and abuse.

For a number of years, the Medicaid Fraud Control Units have been interested in expanding the jurisdiction beyond the Medicaid Program, specifically into other federally funded health care programs such as Medicare. As we are painfully aware, corrupt providers will usually not defraud only Medicaid. An unprecedented agreement was reached this year between the National Association of Attorneys General, HHS, the National Association of Medicaid Fraud Control Units and the Attorney General to expand the jurisdiction of the Units into Medicare and other federally funded health care programs. I support the agreement which is reflected in S. 1088, Title VI, "The Health Care Fraud and Abuse Prevention Act of 1995," which was introduced by Senator Cohen.

In closing, I want to emphasize that the Medicaid Fraud Control Units are viewed as having a national leadership role in detecting and prosecuting fraud and abuse in government funded health care programs. The Units have been successful in serving as a deterrent to health care fraud, in identifying program savings, removing incompetent practitioners from the health care system, and in preventing physical and financial abuse of patients in health care facilities.

Mr. Chairman, I want to thank you for this opportunity to testify today and would welcome any questions you may have.

The CHAIRMAN. Thank you very much, General Vacco.

Ms. Jaggar.

STATEMENT OF SARAH JAGGAR, DIRECTOR, HEALTH FINANCING AND PUBLIC HEALTH ISSUES, U.S. GENERAL ACCOUNTING OFFICE, WASHINGTON, DC; ACCOMPANIED BY THOMAS DOWDAL, ASSISTANT DIRECTOR

Ms. JAGGAR. Thank you, Mr. Chairman.

We're very pleased to be here today to discuss the challenges that Medicare faces in battling health care fraud and abuse. As you mentioned, Mr. Tom Dowdal is an assistant director with our office, and he is here also because many of the points have been made quite eloquently by the panel and also by the Attorney General of New York. I would like to just summarize and make just a few individual points, and I hope that my full statement will be entered into the record.

The CHAIRMAN. Your full statement will be included. It would be very helpful for you to summarize and we'll try to ask a few questions before the bells start to go off.

Ms. JAGGAR. First, it should be clear that instances of fraud and abuse occur in every major category of Medicare provider. Recent fraud investigations revealed cases involving psychiatrists, physicians, medical suppliers, and others, and many of these schemes operate in multiple States.

Second, I think the issue of why Medicare is such an appealing target for exploitation needs to be kept in mind. We have found that certain characteristics of the program create a program ripe for abuse. Specifically, for many supplies and services, Medicare reimbursement far exceeds market rates, and also providers, as was discussed earlier, are allowed to participate in the program without sufficient examination of their qualifications and their business and professional practices.

But why does fraud and abuse persist after the many years of attention to this? As was also discussed earlier, the first cause, we believe, is limited resources. Claims processing and activities to prevent inappropriate payments constitute slightly more than 1 percent of total Medicare spending, and this has decreased over the years. Less than one-quarter of 1 percent goes toward checking for erroneous or unnecessary payments. For example, there are only about three chances out of 1,000 that a Medicare provider will be audited in any given year.

Second, we believe Medicare's controls against fraud have not kept up with today's health care environment. Existing controls rely on data derived from statements designed primarily for other purposes. New anti-fraud systems are available and are used today by private insurers. We believe that Medicare may achieve substantial savings by using commercial software to detect billing abuses. And also, providers who defraud or otherwise abuse health care payers have little chance of being prosecuted or of having to repay fraudulently obtained money.

It should be pointed out that the Health Care Financing Administration has a number of initiatives underway to address fraud and abuse but progress is slow. The delay may be in part due to limited resources, as we have already discussed. More significantly, though, Medicare changes require public input, and hence can be cumbersome and time-consuming. In addition there are instances of legal impediments to HCFA's active pursuit of fraud and abuse.

Fraud and abuse provisions now under discussion as part of the current Medicare deliberations focus on both prevention and enforcement activities, and we agree that both areas need attention. On the enforcement side, key features common to several of these proposals, including your own, respond to issues we have identified here and before. Among these are the critical issue of coordination among Federal, State and local law enforcement programs. These are important because fragmentation of responsibility significantly hinders enforcement activities.

We also think that the establishment of a certain and central funding source that supplements regular agency appropriations is a very important addition. Establishment of national data collection programs for reports of final adverse actions against health

care providers, suppliers or practitioners—with access by Federal and State agencies—facilitates prosecution. And making health care fraud a Federal crime is also important.

There are related proposals for more severe monetary penalties and tightening of provisions barring program participation for providers. However, we are concerned that the deterrent effect of these measures may well be offset by proposed changes to the Medicare anti-kickback law and the civil monetary penalties law that would make it much harder to prosecute both criminal and civil penalty cases.

As we told you in a separate correspondence, we fear the result would be a greater potential for fraud with a consequent, negative financial effect on Medicare. Moreover, other proposals would place a number of additional responsibilities on HHS, HCFA and the OIG; for example, the requirement to provide advisory opinions concerning potential safe harbors. If no resources are provided to accomplish these tasks—however laudable the intent—the result could be that anti-fraud and abuse staff are spread too thinly.

Further strains upon scarce resources could result from suggestions to reward individuals reporting abusive or fraudulent behavior on the part of Medicare providers. This is to empower beneficiaries. Without additional resources, this may lead to an even greater backlog of pending investigations and potentially to frustration among those reporting suspected fraud.

With regard to pre-payment detection of inappropriate claims, your own bill, Mr. Chairman, requires Medicare carriers to acquire commercial automatic data processing software to process Part B claims for the purpose of identifying billing code abuses. However, only one proposal to our knowledge addresses yet another issue we have previously raised, and that is the lack of adequate screening for credibility before allowing providers to bill Medicare, and even this proposal focuses only on financial solvency and fiscal integrity.

In closing, we applaud actions to introduce and enforce strict rules regarding fraud and abuse. It is encouraging also to learn of the various HCFA initiatives along these lines. However, we believe that changes that could be implemented and could lead to substantial savings should be expedited. Dollars lost to fraud, waste and abuse place a continuing drain upon an already overwhelmed and overburdened Medicare program.

Mr. Chairman, this concludes our statement and we would be pleased to answer questions.

[The prepared statement of Ms. Jaggar follows:]

United States General Accounting Office

GAO

Testimony

Before the Special Committee on Aging
U.S. Senate

For Release on Delivery
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FRAUD AND ABUSE

Medicare Continues to Be Vulnerable to Exploitation by Unscrupulous Providers

Statement of Sarah F. Jaggar, Director
Health Financing and Public Health Issues
Health, Education, and Human Services Division

GAO/T-HEHS-96-7

Mr. Chairman and Members of the Committee:

I am pleased to be here today to discuss the challenges that Medicare faces in battling fraud and abuse in the health care system. Medicare, the federal program financing health care for the elderly and disabled, is the nation's largest health payer. In 1994, it spent $162 billion on behalf of about 37 million elderly and disabled people. With this in mind, I would like to describe the ways that unscrupulous providers exploit the program, why it is such an appealing target, and why abusive practices persist despite efforts by program managers and law enforcement agencies.

We have estimated that fraud and abuse may account for as much as 10 percent of health care costs and have pointed out many times that Medicare is vulnerable to such exploitation. We devoted two volumes of our "High-Risk" series to this topic, in 1992 and 1995, and have recently issued two related reports: one focusing on abusive billings for therapy services to nursing home residents, the other on excessive payments for medical supplies. My comments draw heavily from these and other recent reports and testimonies on this subject.[1]

In these documents, we have repeatedly emphasized the importance of "upstream" controls that avoid reimbursement for inappropriate or inflated claims for health care services and supplies. However, these controls will never supplant--though they do reduce--the need for enforcement of laws and regulations targeting abusive and fraudulent providers. These "downstream" activities serve the dual purpose of punishment and deterrence. Both categories share the common objective of curbing Medicare fraud and abuse, both are addressed in our testimony today, and both are targeted by the provisions of bills submitted in this current Congress.

In summary, the vast majority of Medicare providers seek to abide by program rules and strive to meet beneficiaries' needs. Nevertheless, Medicare is overwhelmed in its efforts to keep pace with, much less stay ahead of, those bent on cheating the system. Our recent investigations of Medicare fraud and abuse have implicated home health agencies, medical suppliers, pharmacists, rehabilitation therapy companies, and clinical laboratories, among others. They are attracted by the high reimbursement levels for some supplies and services, and the few barriers to entry into this lucrative marketplace. Once engaged in these profitable activities, exploitative providers too often escape detection because of inadequate claims scrutiny, elude pursuit by law enforcement authorities because of the authorities' limited resources and fragmented responsibilities, and face little risk of speedy or appropriate punishment.

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[1]See appendix I for a list of reports and testimonies addressing this exploitation.

BACKGROUND

Medicare falls within the administrative jurisdiction of the Health Care Financing Administration (HCFA) of the federal Department of Health and Human Services (HHS). HCFA establishes regulations and guidance for the program and contracts with about 72 private companies--such as Blue Cross and Aetna--to handle claims screening and processing and to audit providers. Each of these commercial contractors works with its local medical community to set coverage policies and payment controls. As a result, billing problems involving waste, fraud, and abuse are handled, for the most part, at the contractor level. This arrangement was prompted by concerns when the program was established in the mid-1960s that the federal government, which lacked extensive claims processing expertise and experience, would prove incapable of providing service comparable to that of private insurers.

FRAUD AND ABUSE ARE FOUND
ACROSS THE SPECTRUM OF MEDICARE PROVIDERS

Our studies have identified instances of fraud and abuse in every major category of Medicare provider. A review of recent fraud investigations revealed cases involving psychiatrists, physicians, clinical laboratories, podiatrists, dentists, medical suppliers, and others. And many of these schemes operated in multiple states.

Nursing home residents are often a primary target of provider schemes to bill for unneeded or excessive services or items. Moreover, abusive or fraudulent billing by providers serving nursing home residents is widespread. Table 1 provides typical examples of Medicare fraud that occurs in nursing homes, drawn from completed or active fraud investigations undertaken by Medicare contractors or by the HHS Office of the Inspector General (OIG). Even in this limited context, exploitation can be found across the provider spectrum.

Table 1: Examples of Medicare Fraud in Nursing Homes

Type of provider	Fraudulent behavior
Psychiatrist	Billed for sessions not provided and tests not done; averaged 25.7 45- to 50-minute sessions per day
Physician	Billed for flu shots offered "free" to nursing home residents
Physical lab	Received over $2 million from Medicare for medically unnecessary trans-telephonic electrocardiograms
Clinical lab	Received reimbursement for excessive transportation costs for specimens--corresponding to over 4.2 million miles in 2 years
Medical supplier	Submitted claims for huge quantities of surgical dressings, far exceeding demonstrated need
Podiatrist	Submitted claims for complex procedures, whereas services provided were for routine foot care not covered by Medicare
Dentist	Billed for oral cancer examinations while providing routine dental care not covered by Medicare

Many instances of abusive practices are not pursued as fraud, which requires proof of intentional wrongdoing.

-- One supplier of surgical dressings regularly billed Medicare for 60 or more transparent films (a type of dressing) per beneficiary per month. For some beneficiaries, the supplier billed for 120 or more films a month.[2] Recommended industry standards suggest the need for no more than 24 films per month.

-- Another supplier billed Medicare an average of 268 units of tape

[2]The Wound Ostomy and Continence Nurses Society's and Health Industry Distributors Association's draft recommendations on utilization levels for surgical dressings call for using up to two transparent films per dressing change. In addition, these types of dressings should be changed no more than two to three times per week.

per beneficiary during a 15-month period.[3] The average for all suppliers was 60 units during the 15-month period. Some beneficiaries received between 180 and 720 units of tape in 1 month. Using a 10-yard roll of tape, a common industry length, these beneficiaries would have been wrapped in 60 to 240 yards of tape per day.

-- At least four suppliers regularly billed Medicare for 30 or more drainage bottles a month for each beneficiary. This is 90 times more than the proposed standard of one bottle every 3 months.[4] These four suppliers billed 79 percent of all the drainage bottles billed to this Medicare contractor.

-- One supplier billed Medicare for an average of nine urinary leg bags per beneficiary a month. For some beneficiaries, the supplier billed for one leg bag a day, or 15 times more than proposed standard of two leg bags a month.[5] In total, this supplier billed Medicare for 50,834 leg bags, or 21 percent of all leg bags billed to this Medicare contractor over 15 months.

FACTORS MAKING MEDICARE
AN APPEALING TARGET FOR EXPLOITATION

Certain characteristics of the Medicare program and the way it is administered create a climate ripe for abuse by unscrupulous providers. For many supplies and services, Medicare reimbursement far exceeds market rates. And providers are allowed to participate in the program without sufficient examination of their qualifications and their business and professional practices.

Above-Market Rates for Many
Services Encourage Oversupply

Unlike more prudent payers, Medicare pays substantially higher than market rates for many services as the following examples show:

-- OIG reported in 1992 that Medicare paid $144 to $211 each for home blood glucose monitors when drug stores across the country sold them for under $50 (or offered them free as a marketing

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[3]According to the Health Industry Distributors Association, normal tape usage is no more than two rolls per dressing change.

[4]According to the Medicare contractor's draft payment and coverage policy, drainage bottles are usually changed once every 3 months.

[5]According to the Medicare contractor's draft payment and coverage policy, leg bags are usually replaced twice a month.

ploy).[6] HCFA took nearly 3 years to reduce the price it pays to $59.

-- For one type of gauze pad, the lowest suggested retail price is currently 36 cents. The Department of Veterans Affairs (VA) pays only 4 cents. Medicare, however, pays 86 cents for this pad. Indeed, Medicare pays more than the lowest suggested retail price for more than 40 other surgical dressings. Medicare pays more than VA for each of the nine types of dressings purchased by both VA and Medicare. For all practical purposes, HCFA is prohibited from adjusting the prices for these and similar supplies.[7]

-- Medicare was billed $8,415 for therapy to one nursing home resident, of which over half--$4,580--was for charges added by the billing service for submitting the claim. This bill-padding is permissible because, for institutional providers, Medicare allows almost any patient-related costs that can be documented.

The excessive rates Medicare pays for therapy services are in part responsible for the cost growth in an entire industry that has grown and flourished out of a federal requirement to assess nursing home residents for their need for rehabilitation therapy services. From 1990 to 1993, claims submitted to Medicare for these services tripled to $3 billion. Medicare has been charged rates as high as $600 per hour, though physical, occupational, and speech therapists' salaries, even when fringe benefits are factored in, range from under $20 to $32 per hour. Although Medicare may ultimately pay somewhat under the $600 per hour price, it pays many times more than the average salary range. In one documented Tennessee case, the speech therapist's salary and benefits for 1 hour's therapy (rounded) amounted to $19. Yet the total bill was

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[6]Home blood glucose monitors enable diabetic individuals to determine the adequacy of their blood glucose levels. The manufacturers have an incentive to promote the sale of their brand of monitor to ensure future sales of related test strips. According to HCFA, the income generated in 1 month by the sale of test strips can exceed the total income generated from the sale of the monitors.

[7]42 U.S.C. 1395m(i) required HCFA to establish a fee schedule for surgical dressings based on average historical charges. However, because the benefit was expanded, HCFA did not have such data. Instead, it set fees on the basis of the median price in supply catalogs. The median price is by definition higher than the lowest price (given any variation at all). HCFA cannot change the methodology for determining the fee schedule nor can it adjust the schedule if retail prices decrease. While HCFA is authorized to increase payments annually based on the Consumer Price Index, it lacks authority to reduce such payments.

$172--$34 for the patient's copayment and $138 billed to Medicare (of which auditors allowed $110 as a reimbursable cost--almost 6 times what the therapist was paid).[8]

In response to such instances of inappropriate billings for therapy services, HCFA is developing guidelines to limit reimbursement rates. However, HCFA contacts told us that resources are not available to routinely check market prices for all items covered by Medicare. Yet such excessive payment rates can encourage an oversupply of services and thus foster a climate ripe for abuse. Furthermore, our work has shown that HCFA's inability to systematically review payment rates as technologies mature and become more widely used, and as providers' costs per service decline, can support the proliferation of costly technology. Magnetic resonance imaging (MRI) equipment is a case in point, as we reported in 1992.[9] High Medicare payments for MRI scans supported a proliferation of MRI machines in some states. In the absence of systematic adjustment, the Congress has had to act several times, specifically reducing rates for various covered benefits, such as overpriced procedures, selected durable medical equipment items, clinical lab tests, intraocular lenses, computerized tomography (CT) scans, and MRIs.

Medicare Does Not Adequately Screen Providers for Credibility

For certain provider types, Medicare's requirements to obtain authorization to bill the program are so superficial that these providers' credibility cannot be assumed. The result is that too often Medicare loses large sums to providers and suppliers that never should have been authorized to serve program beneficiaries. This problem has become more acute as providers that are less scrutinized or more transient than doctors and hospitals use elaborate, multilayered corporations to bill Medicare.

The following examples from our work and the OIG's show instances in which wrongdoers obtained Medicare provider numbers and billed the program extensively over the past several years:

-- Five clinical labs (to which Medicare paid over $15 million in 1992) have been under investigation since early 1993 for the alleged submission of false claims. The labs' mode of operation was to bill Medicare large sums over 6 to 9 months; whenever a lab received inquiries from Medicare, it went out of business.

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[8]For further information on abuses related to rehabilitation therapy, see Medicare: Tighter Rules Needed to Curtail Overcharges for Therapy in Nursing Homes (GAO/HEHS-95-23, Mar. 30, 1995).

[9]Medicare: Excessive Payments Support the Proliferation of Costly Technology (GAO/HRD-92-59, May 27, 1992).

-- A medical supply company serving nursing facility patients obtained more than 20 different Medicare provider numbers for companies that it controlled. The companies, all in the same state, were nothing more than shells that allowed the supplier to spread its billings over numerous provider numbers to avoid detection of its overbillings.

-- A Georgia Medicare contractor reported that the program authorized a company to bill for therapy services even though it had no salaried therapists and was essentially a storefront office operated by one clerical employee. The shell company billed Medicare for services provided to nursing home residents through two therapy agencies with which it subcontracted. The company's contractual relationship with the nursing home entitled it to add to its claims an 80-percent markup over what the company paid the therapy agencies. As a result, a company that appeared to exist solely for the purpose of billing Medicare added in 1 fiscal year about $135,000 in administrative charges to the costs of the therapy services.

-- Another shell company we identified had no staff. Simply by creating a "paper organization," with no office space or employees, an entrepreneur added $170,000 to his Medicare reimbursements over a 6-month period. The entrepreneur simply reorganized his nursing home and therapy businesses so that a large portion of his total administrative costs flowed through the shell therapy company and could thus be allocated directly to Medicare.

HCFA's Program Integrity Group is examining ways of limiting participation of suppliers and providers to those that appear to be legitimate business entities. The group is concerned, however, about the reporting burden and costs that new requirements may pose for honest providers.

ABUSES PERSIST BECAUSE OF INADEQUATE DETECTION, PURSUIT, AND PUNISHMENT OF OFFENDERS

A number of factors combine to produce an environment in which opportunities persist to overbill Medicare by billions of dollars. Monitoring of claims may fail to detect overpriced or overutilized services. Even where controls exist to signal aberrancies, many cases are not investigated. And the few offenders convicted of fraud face minimal and much delayed sanctions.

In the current fiscal environment, limited resources contribute to these inadequacies. Although payment of claims is the program's chief administrative function, claims processing and activities to prevent inappropriate payments constitute slightly more than 1 percent of total Medicare spending. Less than one-quarter of 1 percent goes toward checking for erroneous or

unnecessary payments.

Evidence of Abusive Billing Suggests Medicare's Checks on Claims Payments Are Inadequate

Medicare's claims processing contractors employ a number of automated controls to prevent or remedy inappropriate payments.[10] Although these measures are effective in some instances, abusive claims costing billions of dollars escape detection. For example, contractors that process claims for medical equipment and supplies do not necessarily review high-dollar claims for newly covered surgical dressings. In consequence, one such contractor paid $23,000 when the appropriate payment was $1,650. Similarly, Medicare paid a psychiatrist over a prolonged period for claims that represented, on average, nearly 24 hours a day of services. Automated controls failed to identify either of these abuses.

Medicare's controls against fraud have not kept pace with today's health care environment in which the number of claims processed has risen dramatically--from 484 million in 1989 to almost 800 million (estimated) in 1995. Existing controls rely on data that may identify potential fraud but are derived from systems designed primarily for other purposes. New antifraud systems are available and are used today by private insurers, some of whom are also Medicare contractors. In addition, almost 200 private insurers, including 13 of the 20 largest, now use commercial systems to detect code manipulation--a type of billing abuse that affects all insurers--whereas Medicare's abilities to do so are limited. In testimony earlier this year, we reported the results of our study on private sector computer software controls used to detect such coding abuses.[11] We compared what Medicare actually paid providers against what would have been allowed by four commercial firms that market computerized systems to detect

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[10]Some controls are designed to stop processing when claims do not meet certain conditions for payment. For example, one control flags claims that exceed the allowed threshold of 12 chiropractic manipulations a year per beneficiary. Other controls automatically deny claims or recalculate payment amounts. A third kind of control, postpayment review of data, is intended to enable Medicare to spot patterns and trends of unusually high spending.

[11]See Medicare Claims Billing Abuse: Commercial Software Could Save Hundreds of Millions Annually (GAO/T-AIMD-95-133, May 5, 1995) and Medicare Claims: Commercial Technology Could Save Billions Lost to Billing Abuse (GAO/AIMD-95-135, May 5, 1995).

miscoded claims.[12] We invited each firm to reprocess over 200,000 statistically selected claims that Medicare paid in 1993. On the basis of this sample, we estimated that had Medicare used this commercial software, the government would have saved hundreds of millions of dollars by detecting these billing abuses.

Enhancement of payment controls is problematic in the current fiscal environment. Contractor resources are a major factor here. On a per claim basis, funding for contractors has declined in recent years, as shown in table 2. As a consequence, we have found instances where automated controls that flag claims for further review have been turned off for lack of staff to follow up.

Table 2: Per Claim Funding of Medicare Contractors for Selected Activities

Activity	1989 budget (actual)	1995 budget (estimated)	Percentage decrease	
			Not adjusted for inflation	Adjusted for inflation
Medical review of claim	$0.32	$0.15	54.4	61.8
All payment safeguards	0.74	0.50	32.7	43.6
Total contractor budget	2.74	2.05	25.1	37.2

Although heavier reliance on automated controls that do not require manual review would help, automation alone will not solve the problem of decreasing resources because many decisions require the judgment of trained medical personnel. Noting that every dollar spent on Medicare safeguard activities returns at least $11, we and others have proposed that additional funds be provided to at least keep pace with the growth in claims processed. In effect, by not adequately funding these activities, the federal government is missing a significant opportunity for increased control over Medicare program costs.

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[12]Providers bill their charges to Medicare according to the American Medical Society's Current Procedural Terminology Handbook, which contains codes for almost every medical procedure. By manipulating these codes, a provider can charge Medicare more than the appropriate code would permit.

Penalties for Wrongdoing:
Too Little, Too Late

Currently, providers who defraud or otherwise abuse health care payers have little chance of being prosecuted or of having to repay fraudulently obtained money. Few cases are pursued as fraud. Even when they are, many are settled without conviction, penalties are often light, and providers frequently continue in business. These are characteristics of health care fraud (and of white-collar crime in general) and are not confined to Medicare. They are variously attributed to the complexity of cases, lack of resources, necessity for interagency coordination, and uncertainty of outcome. In recent testimony, the Special Counsel for Health Care Fraud at the Department of Justice noted that health care fraud cases are extremely resource-intensive and are among the most document-intensive of all white-collar crime.[13]

Potentially fraudulent activities are investigated by Medicare's claims processing contractors, OIG's headquarters and regional offices, and law enforcement agencies at all levels. The lack of resources hampers investigations for each group and leads to extended delays in case resolution. For example, our recent investigation of inappropriate therapy billings for Medicare beneficiaries in nursing homes traced one case from the initial beneficiary complaint through OIG's close-out. This case took almost 3 years, and even then the resolution was inconclusive.

The contractors are the first line of defense. Fraud units at each contractor site investigate leads from beneficiaries and other sources and refer persuasive cases to OIG, whose regional and headquarters offices decide whether to become further involved and whether to seek civil or administrative sanctions. Criminal action is the province of the Department of Justice, which can also initiate civil actions in federal court. In Medicare cases, OIG investigators provide the information on which the Department of Justice bases its decision. OIG may also refer cases declined by the Department of Justice to local or state law enforcement agencies.

Many fraud cases are negotiated among the various parties involved before conviction to explore possible plea bargains. While the cases are developed at regional OIG offices, they must be reviewed and approved by headquarters, where delays result because there are only three qualified and available negotiators for the entire country. Cases settled through such negotiation offer

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[13]Statement by Gerald M. Stern, Special Counsel, Health Care Fraud, Department of Justice, before the House of Representatives, Committee on Government Reform and Oversight, Human Resources and Intergovernmental Relations Subcommittee, concerning Medicare and Medicaid fraud and abuse (June 15, 1995).

providers an opportunity to avoid being "excluded" from (prohibited from billing) Medicare.[14] Ninety percent of cases OIG judges to have merit are settled through negotiation.

In some instances, as a result of negotiation, corporate providers can continue their program participation despite egregious Medicare fraud. Recently, a clinical laboratory company operating nationwide acknowledged over $100 million in fraud committed against Medicare, Medicaid, and CHAMPUS[15] over a 4-year period. The lab was allowed to negotiate a civil settlement including language that specifically permitted its continued participation in all three programs.

Even when exclusion is imposed, this information can be slow to reach contractors and other affected parties despite recent improvements in the process of notification. Providers who continue to bill after exclusion are not always caught right away; indeed, providers who move from state to state or who use more than one provider number may continue to obtain Medicare reimbursement indefinitely.

OIG is working with HCFA in seeking a nationwide uniform provider agreement that prohibits paying excluded individuals. They are also seeking expanded authority to act against culpable owners of excluded companies. Currently, the owner of such a company is free to reincorporate or start another business without fear of exclusion.

RECENT INITIATIVES TARGETING
HEALTH CARE FRAUD AND ABUSE

In the past, HCFA generally placed more emphasis on program safeguards--designed to curb fraud, waste, and abuse--than did private insurers. That is true no longer. Response to the problems of inappropriate and excessive billings noted in our recent reports has been slow. The delay may be in part due to

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[14]The Secretary of HHS has the authority to exclude health care providers from Medicare for a number of reasons and has delegated these various authorities to OIG. Program exclusion is mandatory following convictions for Medicare or Medicaid program-related crimes or for patient abuse and neglect. Under other conditions, OIG can exercise judgment as to whether exclusion is appropriate. According to OIG, very few companies or other entities are excluded from the program: over the past 10 years, 90 percent of the exclusions have targeted individuals.

[15]CHAMPUS--the Civilian Health and Medical Program of the Uniformed Services--is a federal medical program for military dependents and retirees that pays for care received from civilian hospitals, physicians, and other providers.

limited resources. More significantly, though, as a public program, Medicare changes require public input and hence can be cumbersome and time-consuming. As we reported last month, past experience suggests that changes made by HCFA will typically be contested.[16] In considering cost-saving initiatives, HCFA must therefore weigh the resulting expense and disruption as well as the risk of ultimate failure against anticipated savings.

Recently, HHS has initiated several efforts, alone and in conjunction with other agencies, to address long-standing problems with inappropriate payments. First, HCFA let a contract to design a single automated claims processing system--called the Medicare Transaction System (MTS)--that promises greater efficiency and effectiveness. By replacing the 10 different claims processing systems now used by Medicare contractors with a single system, MTS is expected to serve as the cornerstone for HCFA's efforts to reengineer its approaches to managing program dollars. The new system, which promises to format claims data uniformly and produce comparable payment data, is expected to provide HCFA with prompt, consistent, and accurate management information. However, full implementation is not scheduled until September 1999.

HCFA's second initiative involves giving greater prominence to fraud and abuse activities in Medicare. One individual now serves as a focal point for health care fraud and abuse activities, reporting directly to the Administrator of HCFA. In addition, HCFA recently established special units at each contractor site to develop and pursue fraud cases within the Medicare program. Before the development of these units, following up on fraud allegations and developing cases for referral to OIG were often seen as collateral duties and given low priority.

HHS also recently announced a new antifraud effort, Operation Restore Trust, to be run jointly by OIG, HCFA, and the Administration on Aging. The project is focusing on home health agencies, nursing homes, and durable medical equipment companies in five states: California, Florida, Illinois, New York, and Texas.

In August, responding to a draft of our September report cited previously, a HCFA official told us of additional measures:

-- HCFA has asked all contractors to regularly screen claims that represent unusually high dollars or volume of services and is compiling a comprehensive collection of "common sense" edits to be installed in the contractors' processing systems.

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[16]Medicare Spending: Modern Management Strategies Needed to Curb Billions in Unnecessary Payments (GAO/HEHS-95-210, Sept. 19, 1995).

-- HCFA is also pursuing a Provider/Supplier Enrollment Initiative to enhance HCFA's control over entry into the Medicare program and thus better safeguard the program against fraud and abuse. In a related effort, HCFA is participating in a joint federal and state initiative to develop unique provider identifiers.

-- Medicare contractors are piloting the use of commercial databases that compile information on the stability and business histories of providers and suppliers as one way of screening out high-risk providers and suppliers.

CURRENT PROPOSALS FOR CURBING FRAUD AND ABUSE

Bills introduced in the current Congress to address fraud and abuse have focused on both prevention and enforcement activities. On the enforcement side, key features common to several of these proposals, including your own, respond to issues we have identified here.

-- Coordination among federal, state, and local law enforcement programs. As we pointed out earlier in this testimony, fragmentation of responsibility significantly hinders enforcement activities.

-- Establishment of a central funding source--intended to increase and not supplant regular agency appropriations--to support health care anti-fraud and abuse activities. Again, we identified lack of resources as a factor contributing to delayed and inadequate sanctions.

-- Establishment of a national data collection program for reporting of final adverse actions against health care providers, suppliers, or practitioners, with access by federal and state government agencies and health plans. Such a provision could also contribute to the enhancement of interagency coordination.

-- Making health care fraud a federal crime. Representatives of the law enforcement community have repeatedly called for such a measure to simplify their task.

There have been related proposals for more severe monetary penalties and tightening of provisions barring program participation for providers violating program restrictions, including--but not limited to--the submission of fraudulent or abusive billings. However, the deterrent effect of these measures may well be offset by proposed changes to the Medicare Anti-Kickback Law and the Civil Monetary Penalties Law that would make it much harder to prosecute both criminal and civil penalty cases. As we told you in earlier correspondence, the result would be a greater potential for fraud, with a consequent negative financial effect on Medicare.

Moreover, other proposals would place a number of additional responsibilities on HHS, HCFA, and OIG--for example, the requirement to provide advisory opinions concerning potential "safe harbors" from anti-kickback restrictions. If no resources are provided to accomplish these tasks, however laudable the intent, the result could be that anti-fraud and abuse staff are spread too thinly.

Further strains upon scarce resources could result from suggestions to reward individuals reporting abusive or fraudulent behavior on the part of Medicare providers, potentially leading to an even greater backlog of pending investigations. A related measure already exists in the form of "qui tam" provisions of the False Claims Act, which allow private individuals to share in monetary recoveries from convicted offenders.

With regard to prepayment detection of inappropriate claims, your own bill, Mr. Chairman, requires Medicare carriers to acquire commercial automatic data processing software to process part B claims for the purpose of identifying billing code abuse, which we identified as a significant problem earlier in this testimony. However, only one proposal, to our knowledge, addresses another major issue we raised--the lack of adequate screening for credibility before allowing providers to bill Medicare--and even this focuses only on financial solvency and fiscal integrity.

CONCLUSIONS

Enhancing the capability to introduce and enforce strict rules regarding fraud and abuse against Medicare likely requires Congressional action. Meanwhile, however, as the nation's largest health payer, HCFA's unique federal role confers the responsibility to lead in the development of effective ways to manage health care expenditures. This would entail such pre-enforcement measures as

-- exploring opportunities to improve care management in settings such as nursing homes where fraud and abuse have been a recurring problem;

-- seeking ways to strengthen requirements for providers that request authorization to bill the program;

-- identifying for its contractors, and helping to implement, those leading-edge technologies that can best flag questionable claims or providers; and

-- facilitating the prompt reduction of obviously inflated prices for Medicare supplies and services.

It is encouraging to learn of the various HCFA initiatives along these lines. However, we are all too aware of the urgency of expediting changes that could lead to substantial savings and of

HCFA's historical pattern of slow response absent specific statutory authority. In the meantime, the dollars lost to fraud, waste, and abuse place a continuing drain upon an already overburdened Medicare program.

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Mr. Chairman and Members of the Committee, I want to thank you for the opportunity to speak before you today. This concludes my prepared statement. I would be pleased to answer any questions.

For more information on this testimony, please call Jonathan Ratner, Associate Director, or Audrey Clayton at (202) 512-7119.

RELATED GAO PRODUCTS

Medicare Spending: Modern Management Strategies Needed to Curb Billions in Unnecessary Payments (GAO/HEHS-95-210, Sept. 19, 1995).

Medicare: Excessive Payments for Medical Supplies Continue Despite Improvements (GAO/HEHS-95-171, Aug. 8, 1995).

Medicare: Antifraud Technology Offers Significant Opportunity to Reduce Health Care Fraud (GAO/AIMD-95-77, Aug. 11, 1995).

Medicare: Modern Management Strategies Could Curb Fraud, Waste, and Abuse (GAO/T-HEHS-95-227, July 31, 1995).

Medicare: Adapting Private Sector Techniques Could Curb Losses to Fraud and Abuse (GAO/T-HEHS-95-211, July 19, 1995).

Medicare: Allegations Against ABC Home Health Care (GAO/OSI-95-17, July 19, 1995).

Medicare: Modern Management Strategies Needed to Curb Program Exploitation (GAO/T-HEHS-95-183, June 15, 1995).

Medicare: Tighter Rules Needed to Curtail Overcharges for Therapy in Nursing Homes (GAO/HEHS-95-23, Mar. 30, 1995).

High-Risk Series: Medicare Claims (GAO/HR-95-8, Feb. 1995).

Medicare: Shared System Conversion Led to Disruptions in Processing Maryland Claims (GAO/HEHS-94-66, May 23, 1994).

Medicare: Inadequate Review of Claims Payments Limits Ability to Control Spending (GAO/HEHS-94-42, Apr. 28, 1994).

Health Care Reform: How Proposals Address Fraud and Abuse (GAO/T-HEHS-94-124, Mar. 17, 1994).

Medicare: Greater Investment in Claims Review Would Save Millions (GAO/HEHS-94-35, Mar. 2, 1994).

High-Risk Series: Medicare Claims (GAO/HR-93-6, Dec. 1992).

Medicare: One Scheme Illustrates Vulnerabilities to Fraud (GAO/HRD-92-76, Aug. 26, 1992).

Health Insurance: Vulnerable Payers Lose Billions to Fraud and Abuse (GAO/HRD-92-69, May 7, 1992).

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The CHAIRMAN. Thank you very much, Ms. Jaggar.

General Vacco, you heard one of my colleagues talk about and suggest that perhaps we ought to form a blue ribbon commission that consists of those who have been convicted of defrauding the system to perhaps go around as a team to advise and instruct prosecutors, overseers in the health care system of exactly how fraud is taking place.

What do you think of that idea?

Mr. VACCO. Well, I understood his analogy to the gaming industry. I happen to think, Senator, that what we do in New York State is perhaps just as beneficial. We work with the providers, the legitimate providers, who instruct us on how the system should work and what we should be on guard for on behalf of those who are trying to rip off the system. I am somewhat concerned about allowing these individuals to play a prominent role in our enforcement and detection scheme. I guess I am offended by the notion—in all due respect to Senator Reid of whom I have a great deal of respect and admiration for—I am somewhat offended by allowing these people to profit by virtue of being paid as government consultants in an area where I think we can obtain the expertise if we already don't have it from other sources.

The CHAIRMAN. I'm not sure he wanted to pay them. It would be more of a citizen advisory group.

Mr. VACCO. Oh, as part of a sentence maybe that we could have encourage judges to sentence them to the Medicaid Fraud Control Unit Advisory Panels?

The CHAIRMAN. Community service—saying, this is how we rob banks. We should bring Willie Sutton in to say this is how we do it and this is what you should watch out for and here are some of the techniques that we use.

Mr. VACCO. I don't mean to make light of it. Obviously, it is something that is done in other arenas. In the gaming industry we see it in organized crime prosecution where we bring in convicted felons and mob members to serve as expert witnesses. So it's not that far-fetched of an idea. I'm just concerned about turning these people into government paid consultants.

The CHAIRMAN. Ms. Jaggar, what about the pay now ask questions later practice that one of our witnesses talked about? Is that a policy we ought to change? I mean, here you're paying a year in advance or a month in advance and you may have a question but will pay anyway and ask to have the issue resolved later. Is that something we should change?

Ms. JAGGAR. It is certainly something to look into, and in fact we believe that through better use of technology, the Health Care Financing Administration might be able to better identify schemes in the early stages when they notice, for example, that a home health agency or a medical supplier was routinely billing let's say, $5,000 a month and then it all of a sudden jumps up to $10,000. They then could go after abuses in a much earlier stage. But the issue really is, of course, that you need to assure that you're providing payments on a routine and regular basis for those people who are not acting fraudulently. The hard task, the important task, is to try to separate out and take action more quickly for those that look like there is a serious question to be followed up on.

The CHAIRMAN. We have criminal sanctions in the bill that is now in conference in the reconciliation package. Do you think we ought to apply these to the managed care situation? You've raised this issue, General Vacco, that we've got a different problem. In the current system the fee for service we've got over-utilization. One of the dangers of going to managed care HMO's will be that of under-utilization so that the capitated fee will be paid. You will have some who will simply not provide the service when it should be provided.

Now is that a type of criminal activity that we can identify that would come under criminal sanctions or is that really getting into a discretionary area of questioning a doctor's decision? Or, should we leave it up to the tort system—assuming we still have a tort system—to allow private citizens to bring lawsuits for medical malpractice? I mean, are we getting into an area that has to be treated differently?

Mr. VACCO. Well, I don't think that it's any different than some of the decisions that are made currently. I mean, right now in the current system there is an awful lot of debate from time to time over the necessity of a test or other types of diagnostic services or provider services. So I think it's just flipping the coin around to the point now where we're going to have providers.

I think as long as we have multi-billions of dollars being expended in the industry, we're going to find some individuals who are going to find those loopholes whether it's in managed care or in the system that we have currently to exploit the system. So while I recognize your concern over law enforcement——

The CHAIRMAN. I'm asking you as a prosecutor.

Mr. VACCO. I think that from a prosecutor's perspective, this is something that we need to focus on in terms of potential criminal responsibility that the under-utilization of this service is as equally problematic.

The CHAIRMAN. It seems to me it's one thing to say that we have a group—let's say, a doctor or a medical clinic that's ordering tests that are unnecessary, or duplicative, or that they're simply going to apply the sink test to. We've had those cases where they take the test and dump them down the sink and simply forge whatever results they want to forge. That's one case. You can then go after that in terms of fraudulent billing, but what do you do when you have a doctor who says, "I don't think that the patient requires this level of treatment and I will not order the MRI in this particular case, or the CAT scan or whatever the treatment might be." Is that going to present a situation that's a much more difficult area to look at.

Mr. VACCO. Far more difficult, and obviously more technical than the obvious overbilling for useless tests, but I think that just as we now look for patterns in terms of overbilling—and that's really the mainstay of our enforcement efforts. We can't—we don't have the resources to engage in the type of oversight that we need to stop the abuses that we heard here earlier this morning. So right now we look at trends, and I think that if we're going to craft legislation to address the managed care circumstances where there is under-utilization, we obviously then have to look at trends. Is the conduct of the physician—is it genuine and consistent with accepted

medical practices or is it being done for some other purpose, and do those trends that we investigate and analyze reveal a less pure intent? I think that if it reveals a less pure intent, we should be provided with the mechanism to go after them.

The CHAIRMAN. You know, one of the criticisms directed toward the legislation that I've authored is that I'm trying to criminalize innocent errors. Is that—do you see that——

Mr. VACCO. Well, Senator, we just recently—not in my office in particular but in New York State—we recently concluded over the course of the summer a case that received an awful lot of notoriety concerning a doctor who was providing abortion services whose patient died, and that doctor was indicted and prosecuted and convicted of murder in the second degree because he failed to use appropriate medical technique and failed to use appropriate intervention when it was clear that the patient that he was delivering a service to had problems. So I think that we already have a scheme. If we are committed as prosecutors to employing the laws that are available to us, and we already have a scheme without necessarily criminalizing malpractice. I'm not suggesting that we criminalize malpractice.

The CHAIRMAN. What I'm suggesting is that many complain about the fact that the legislation that we have authored would end up criminalizing innocent billing errors, and that's something that we try to be sensitive to. That's not our intent. What we are going after are people who are deliberately defrauding the system, and we're looking at patterns. Anyone can make an innocent error. Anyone can hire a clerk who may not measure up to the standards of excellence that would be required, and have one or two or more errors during the course of a billing period. Those are not the errors that we are after. What we are after are the kind of schemes that we've heard so much about over the years, and some of the criticism directed toward the legislation I think is unwarranted but it's out there, and there are very heavy lobbying activities taking place trying to water down some of the tough provisions that I think are necessary.

Mr. VACCO. I urge you to resist that.

The CHAIRMAN. You don't have to talk to me. You're not only preaching to the choir; you're preaching to the preacher. [Laughter.]

The CHAIRMAN. What about Medi-grants? This whole policy of turning as much of the responsibility over as we can to the States. Can the States handle it without any Federal standards or do you think standards are still important in the field of Medicaid?

Mr. VACCO. Well, Senator, I usually am in agreement with the efforts to return much of government to the States. This is one arena where I think that we need to be very careful. If we go to the block grant program, I believe that there needs to be a continuing Federal requirement for the creation and maintenance of these Medicaid fraud control units as separate and distinct entities, and that standards go along with the block grant money for these units.

For instance, without creating new Federal legislation, I would suggest that an incentive be tied into the block grant to cause States to pass mega larceny statutes like we have in New York State. Many States don't have the ability to prosecute providers to

the same extent that we can where providers are looking at 15 years or more in jail for mega larcenies, for the hundreds of thousands or millions of dollars worth of fraud. Many States are still operating on older traditional grand larceny statutes.

While this is a State's rights issue, I do believe that it would be appropriate for the Congress to put in an incentive for the block grant money requiring States to contemplate mega larceny statutes like we have in New York State because I believe the deterrent effect of stiffer jail sentences certainly sends a message to the provider community. But if they look at it and they say that if in State X the most that we can be punished for is a non-mandatory jail conviction with a fine of up to $5,000, there is not that much deterrent impact in that type of statute.

So I think that the block grant money should come with certain restrictions from the Federal Government, and maybe even indeed some inducements to beef up statewide enforcement.

The CHAIRMAN. Let me, first, point out that in the Senate bill the Medicaid fraud units are in tact. That's something we hope to retain in the House-Senate conference right now.

Can I ask you, Ms. Jaggar, what are the implications for having some kind of a reward system for people, beneficiaries who report examples of fraud? Is this something, No. 1, that you think is desirable; and, No. 2, can the agencies handle the amount of calls that may be coming in?

Ms. JAGGAR. Well, in fact many fraud control units and people in the IG offices and so on have told us that the best leads they get are the ones that come from beneficiaries or from providers. I have myself recently received letters—in two different situations from two different physicians through their lawyers—making accusations that we're following up on. So it's a very, very important thing to empower the American people and the people in the health care system. I think that is important to do.

The CHAIRMAN. There is no question that law enforcement depends upon the beneficiaries as the first line of defense. We can't possibly hire enough investigators or prosecutors to go after a system this big, but the issue now is should there be a reward for those who report it? Is that something that would be desirable?

Mr. VACCO. Yes, I believe so. I believe that an award— I mean, again, it's not an inconsistent recommendation with what we do in other arenas of law enforcement. Under Federal forfeiture laws we can provide a percentage of forfeited assets to convicted criminals who cooperate with Federal authorities. In the civil arena we provide the ability of individuals who bring qui tam lawsuits to be able to obtain some benefit if the government recovers as a result of being a whistle blower.

So I think a whistle blower incentive is a prudent idea in this idea, but I would like to go a step forward, if I may, Senator. I think that we ought to provide additional incentive to the Medicaid fraud control units to give them the incentive to go out there and more aggressively pursue these cases knowing that the level of funding that they receive is in some fashion tied into the level of their effort so that we provide an incentive to the informing community and we provide an incentive to the prosecutive community to be more aggressive in this arena.

The CHAIRMAN. Senator Burns—go ahead, I'm sorry.

Ms. JAGGAR. If I might add a concern. I think that it's something that needs to be handled very carefully and thought through very carefully not only because of the potential effect on those agencies that would be required to or have the opportunity to pursue the leads that they get. I think that beneficiaries who report their concerns may have grand expectations that would not be met, and I think that that is dangerous. Say my mother or someone turns in what they consider to be an improper bill—and it could be a very simple thing like I was charged $15 for this and I can buy it for $2.50 at the grocery store or at the drug store—and has an expectation that as a result of having turned it in she will get a refund for that. She then runs into the procedures that will need to be put in place to follow these things, the time that it's going to take and so on. I think you could end up with more people being more concerned about a non-responsive government when that really may not be the case. So we have a concern about that, and I think it needs some careful thinking.

Mr. VACCO. I believe that's an appropriate concern, and my recommendations are geared toward the mega cases where the individual that she speaks of with this singular complaint leads us to the mega case. I think that there should be some incentive for them to help us do that.

The CHAIRMAN. Well, I have many questions I could still pose to you, and perhaps I will ask you to submit a few more answers to some questions that I have for the record.

I want to thank all of you for coming forward today and especially commend what's going on in New York under your leadership.

Mr. VACCO. Thank you, Senator.

The CHAIRMAN. We have cited New York in terms of its Medicaid fraud unit extensively in terms of your aggressiveness and success in combating this type of fraud and abuse, and I also want thank Mary Gerwin, the staff director of the Aging Committee, and Priscilla Hanley for their long efforts to assemble not only this hearing but the many hearings that have gone into the report that was so instrumental in building the foundation for the passage. And, yes, Helen Albert. You can see that when I really need the work done, I turn to a trio of women behind me to really get the work done, and they have been just absolutely outstanding in investigating this area, putting together the staff report last year that really provided the foundation for the passage of the bill, which is now in conference. And I want to extend my thanks to all three for their terrific work.

So, with that, the committee will now stand adjourned.

[Whereupon, at 12:35 p.m., the committee was adjourned, to reconvene at the call of the Chair.]

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